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(54) **ENDOSCOPIC DELIVERY OF RED/NIR
LIGHT TO THE SUBVENTRICULAR ZONE**

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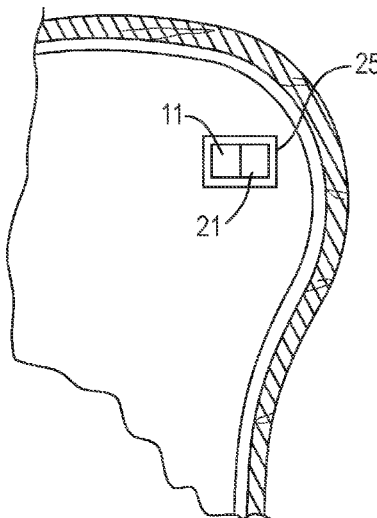
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(57) **ABSTRACT**

Endoscopic delivery of Red/NIR light to the Substantia Nigra
to treat Parkinson's Disease in order to raise the energy levels
in the substantia nigra.

2 Claims, 31 Drawing Sheets



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FIG. 1

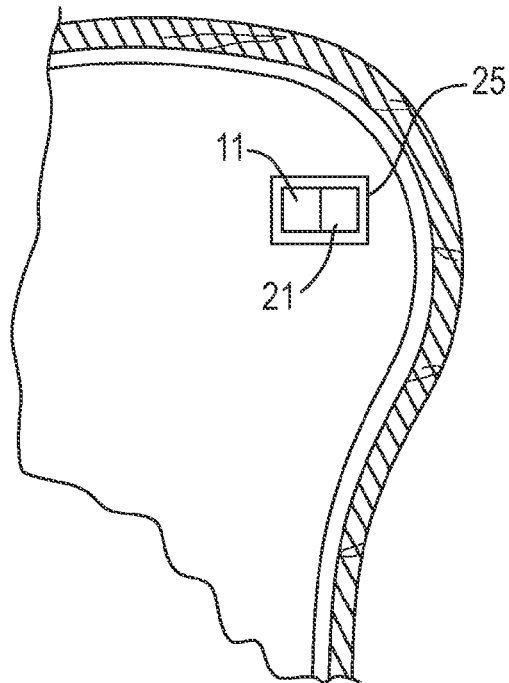


FIG. 2

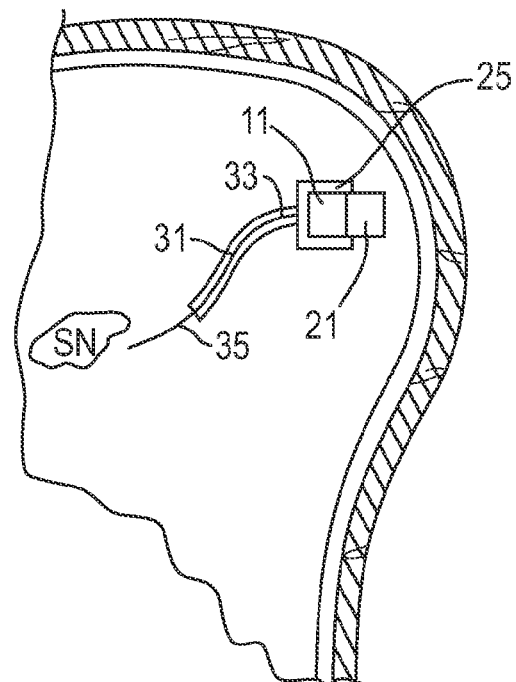


FIG. 3

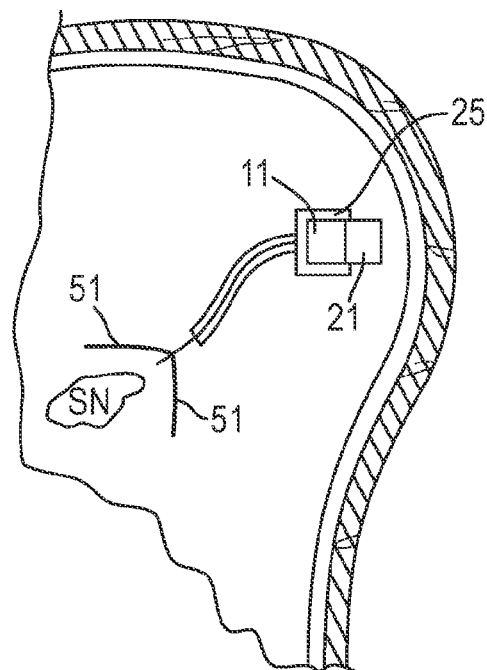


FIG. 4A

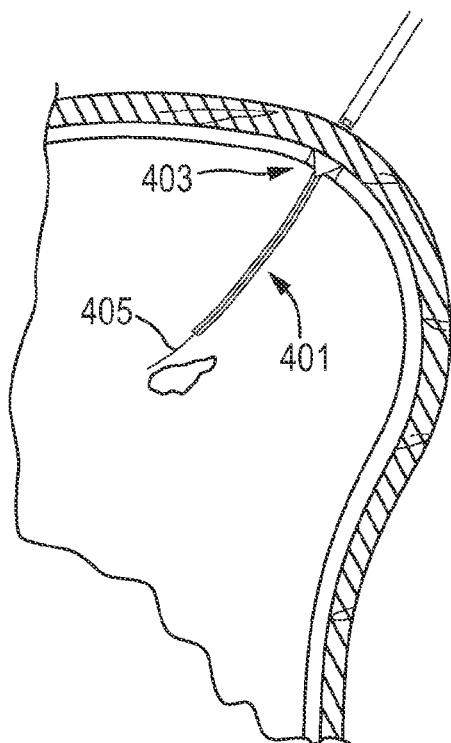


FIG. 4B

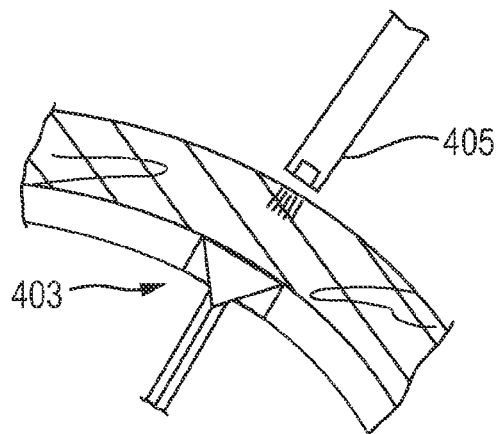


FIG. 4C

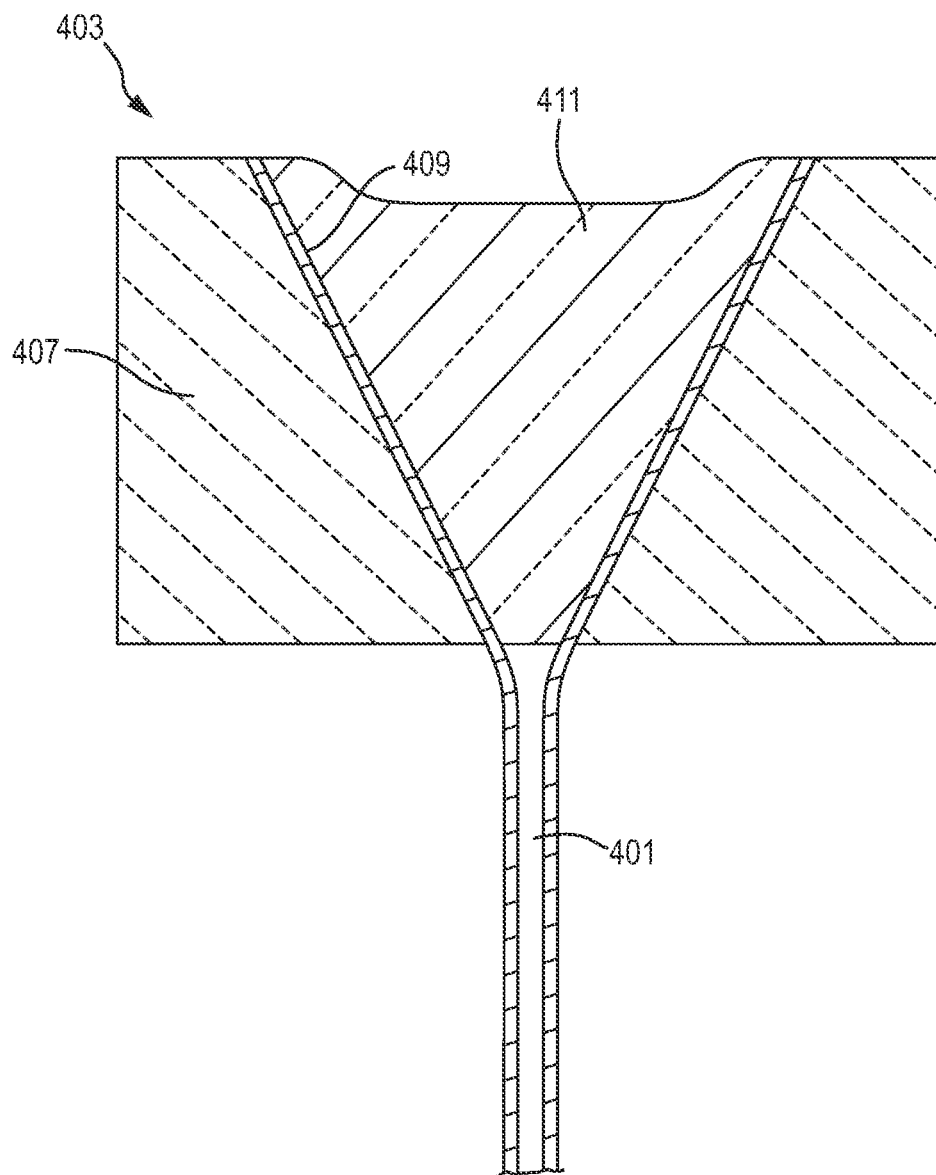


FIG. 5

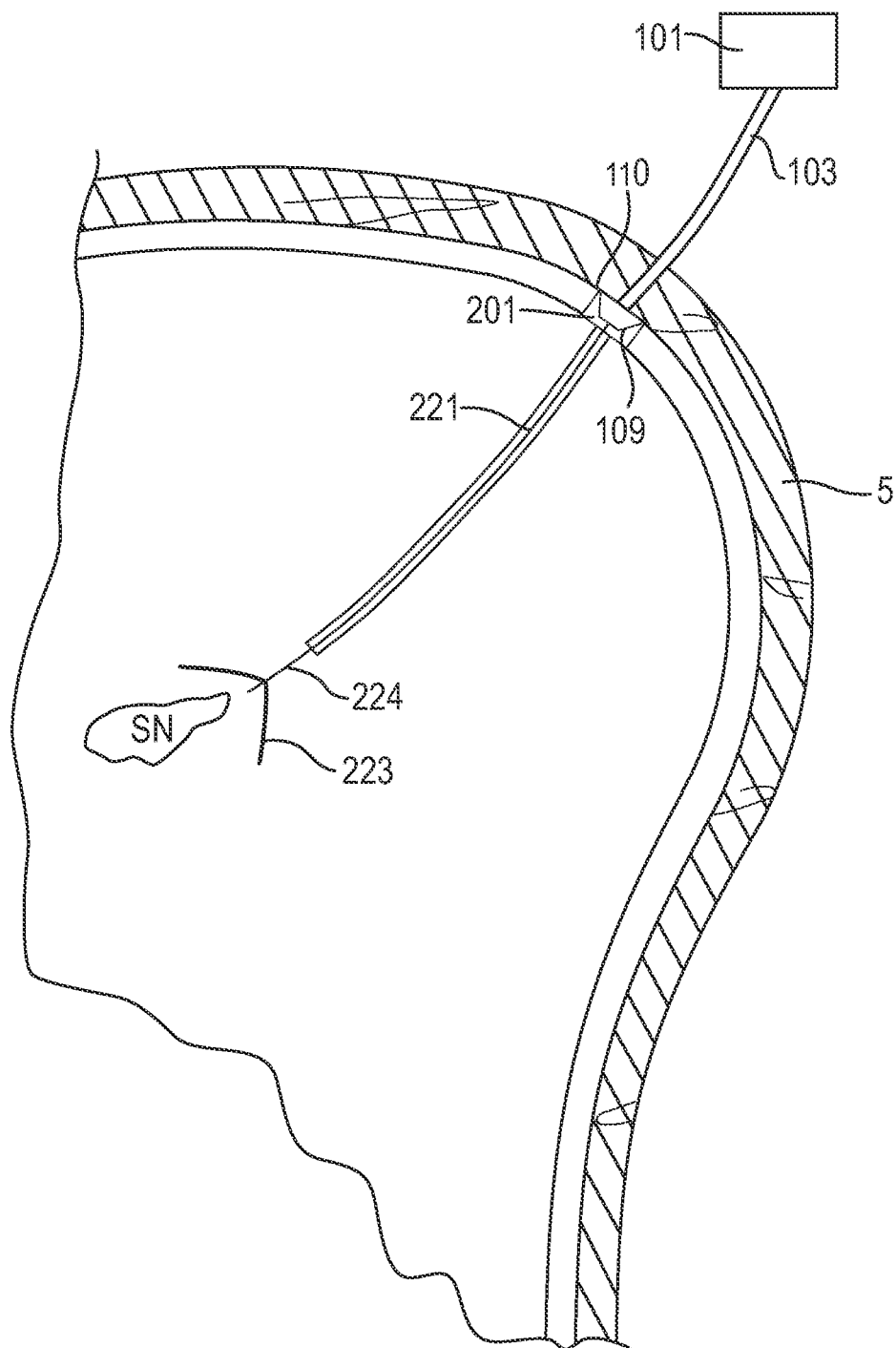


FIG. 6

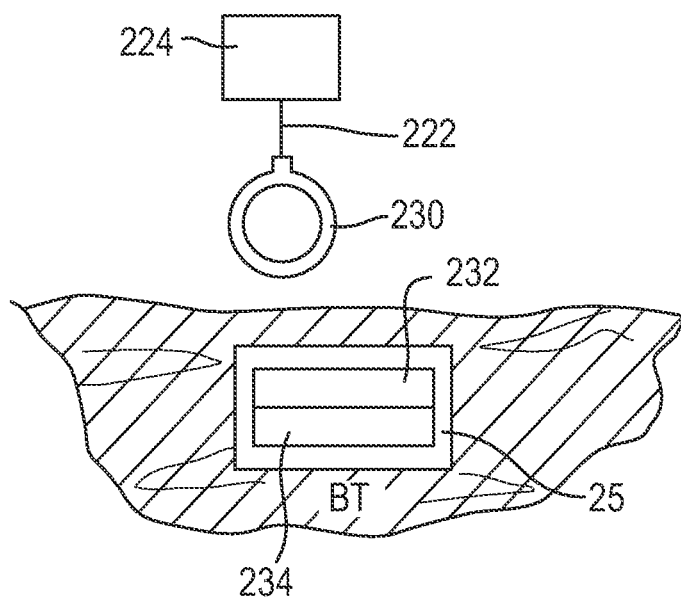


FIG. 7

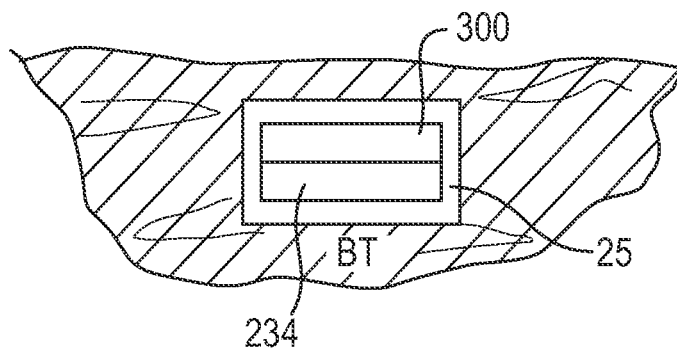


FIG. 8

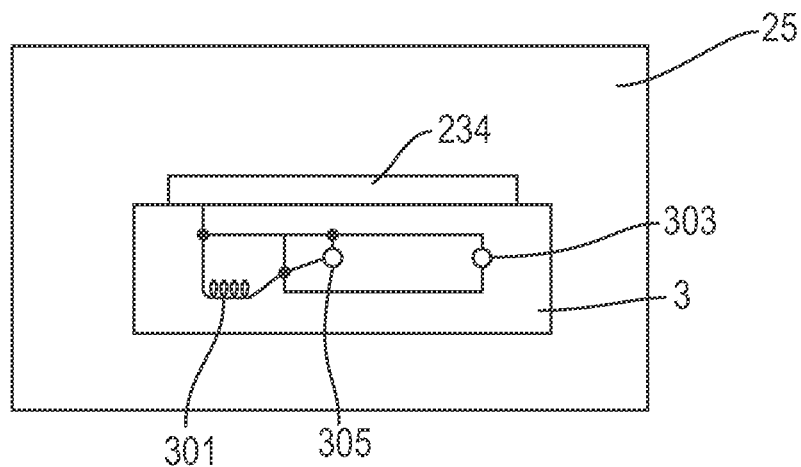


FIG. 9

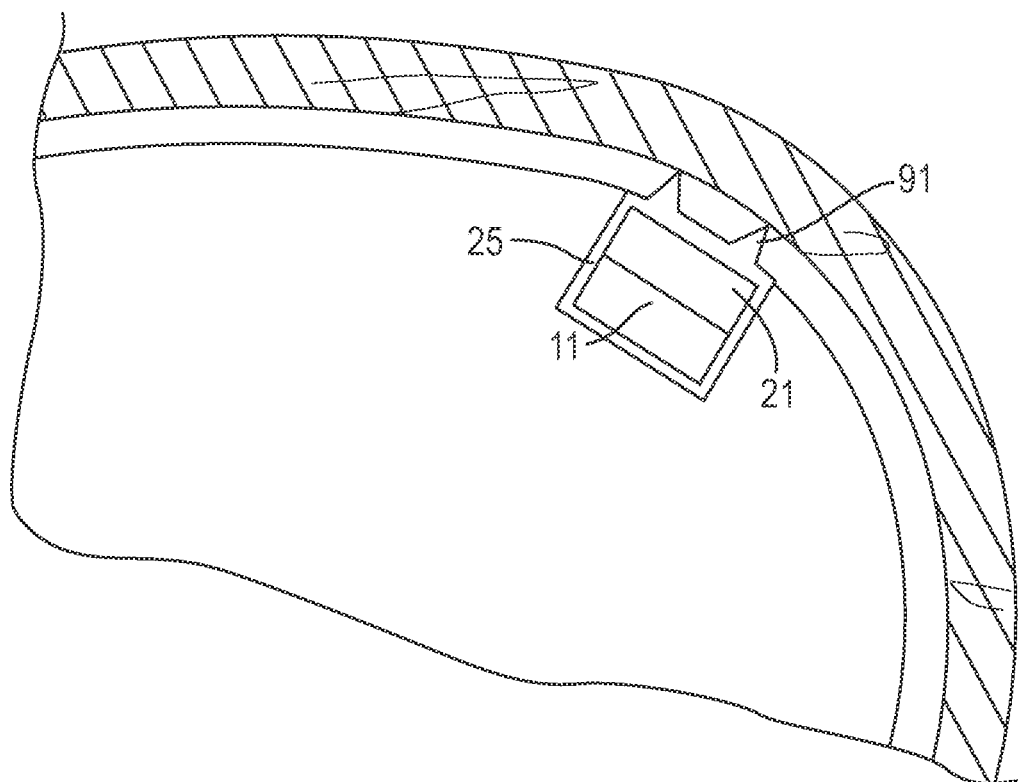


FIG. 10A

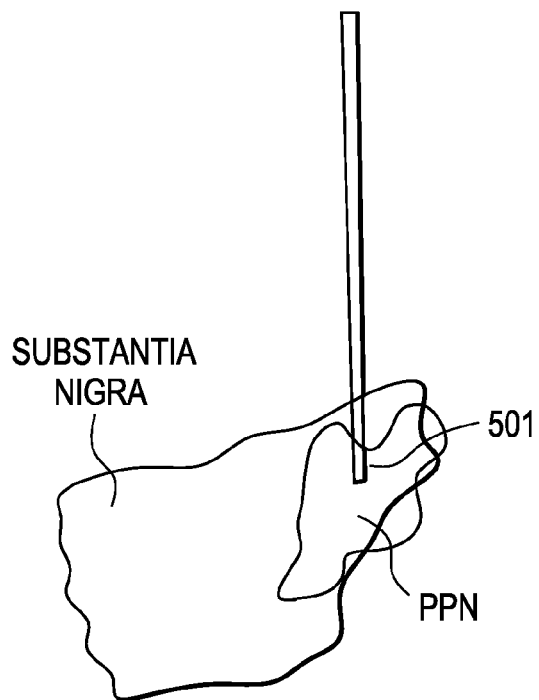


FIG. 10B

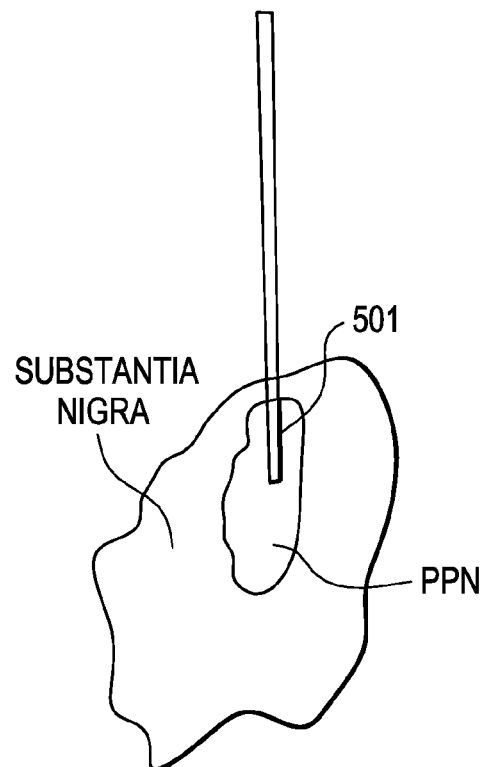


FIG. 10C

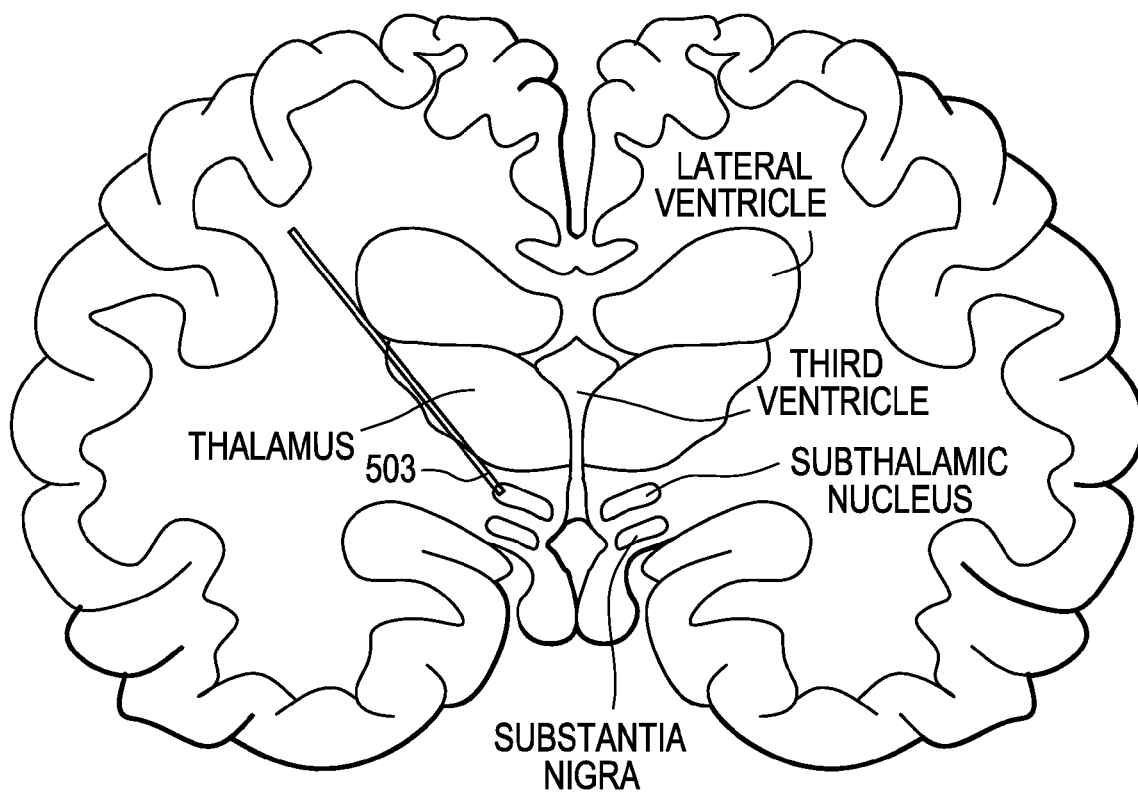


FIG. 11

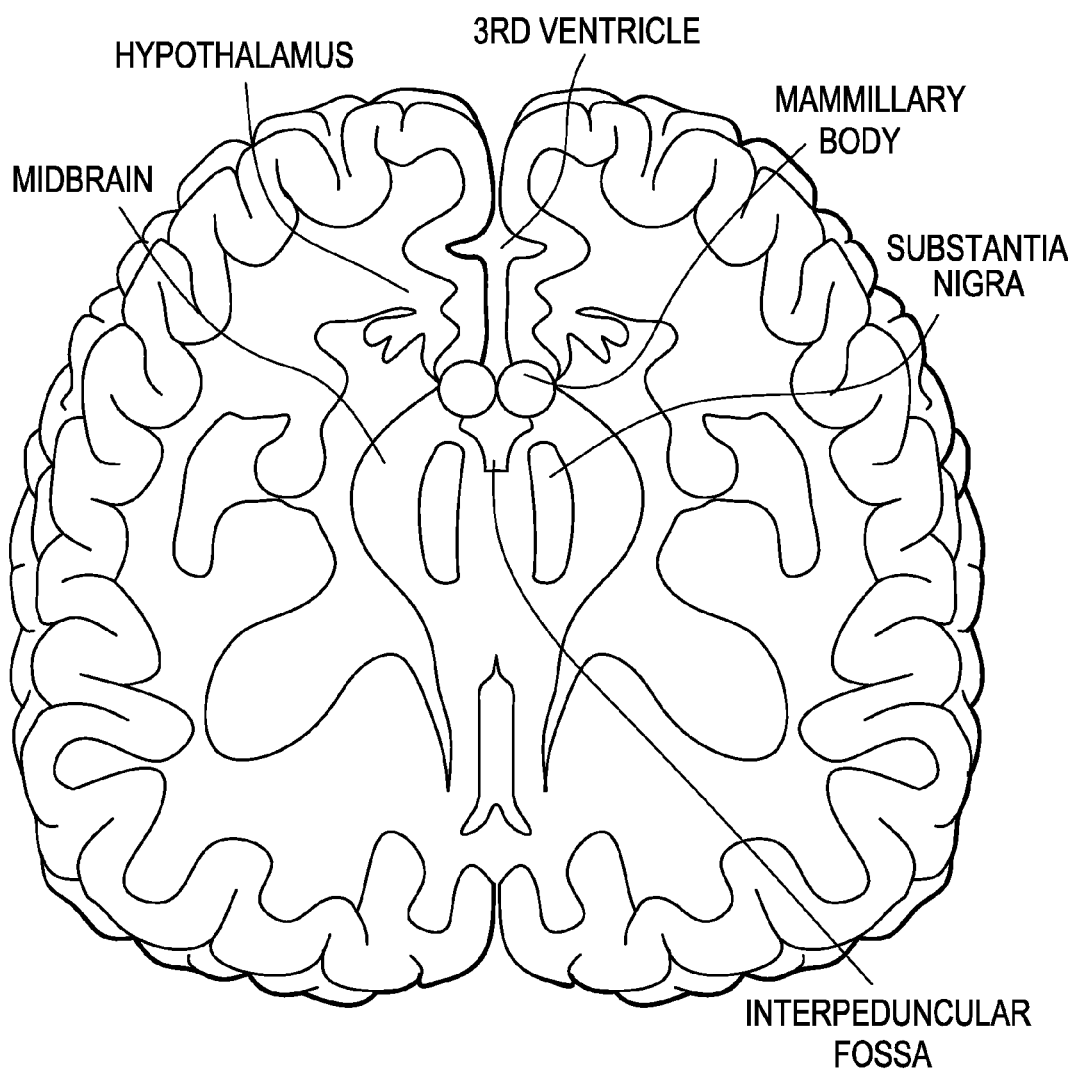


FIG. 12

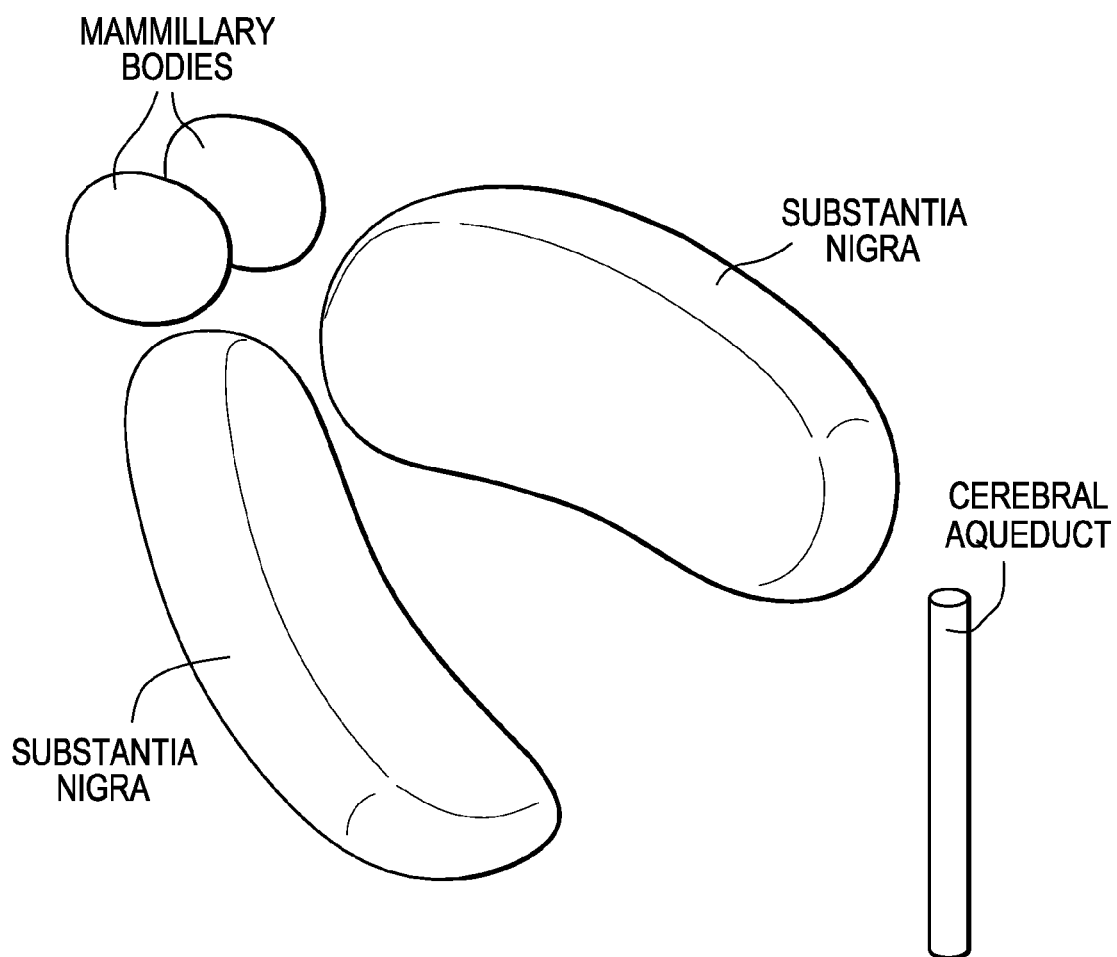


FIG. 13

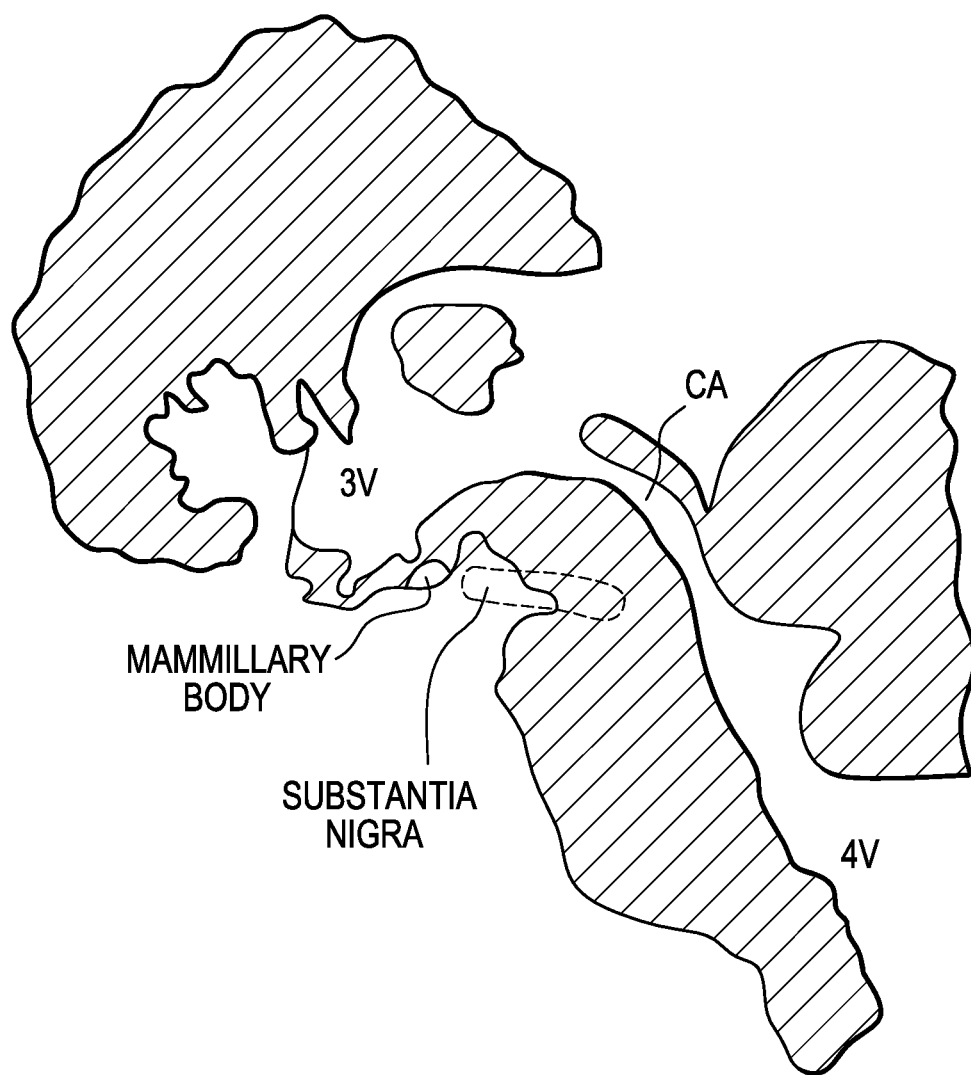


FIG. 14A

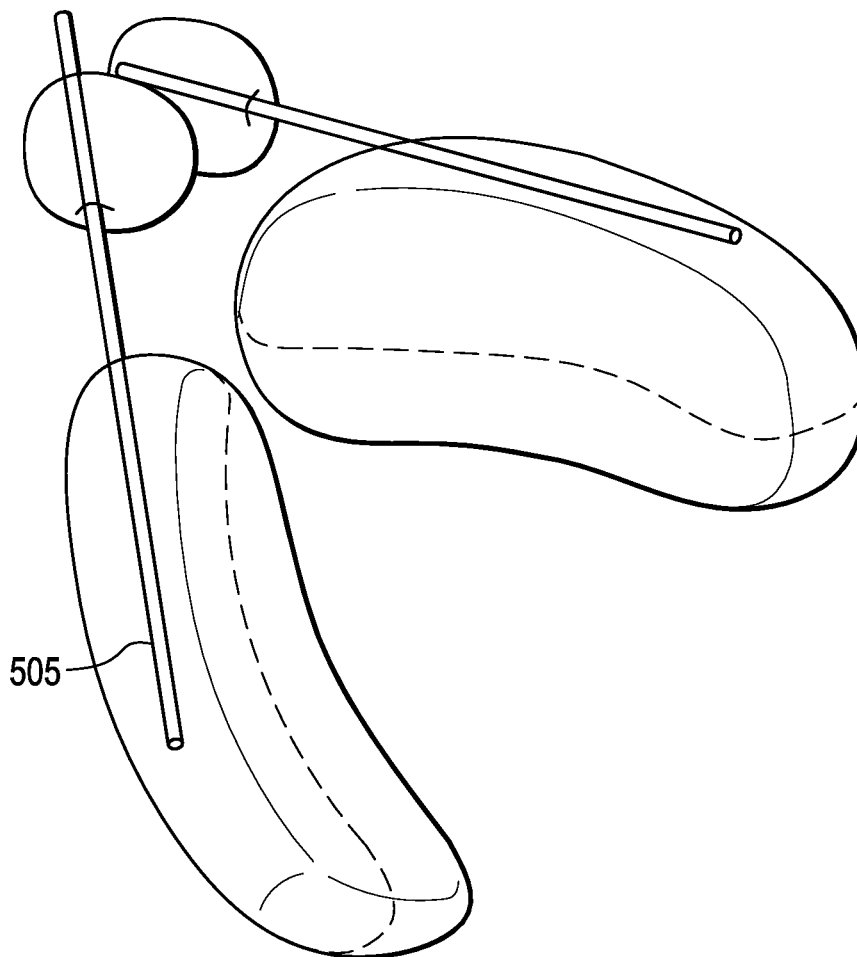


FIG. 14B

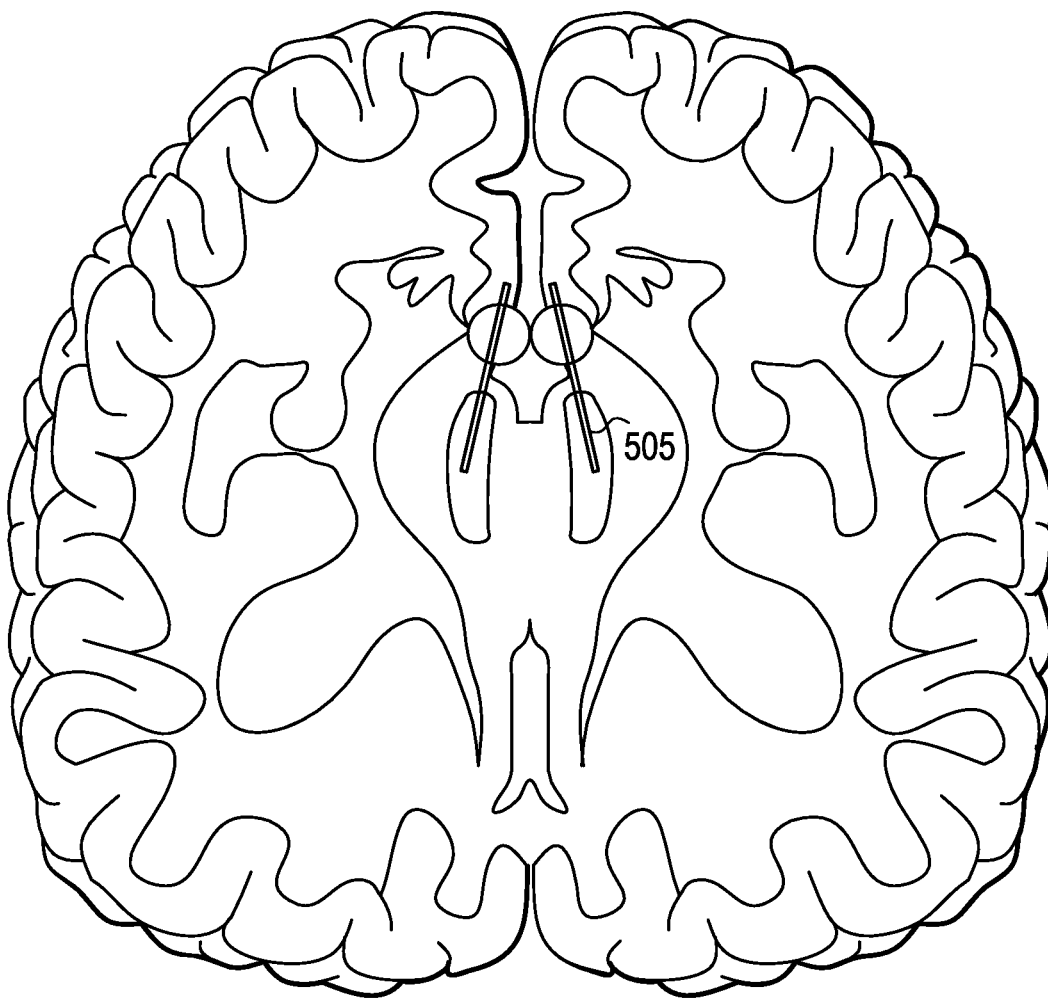


FIG. 15

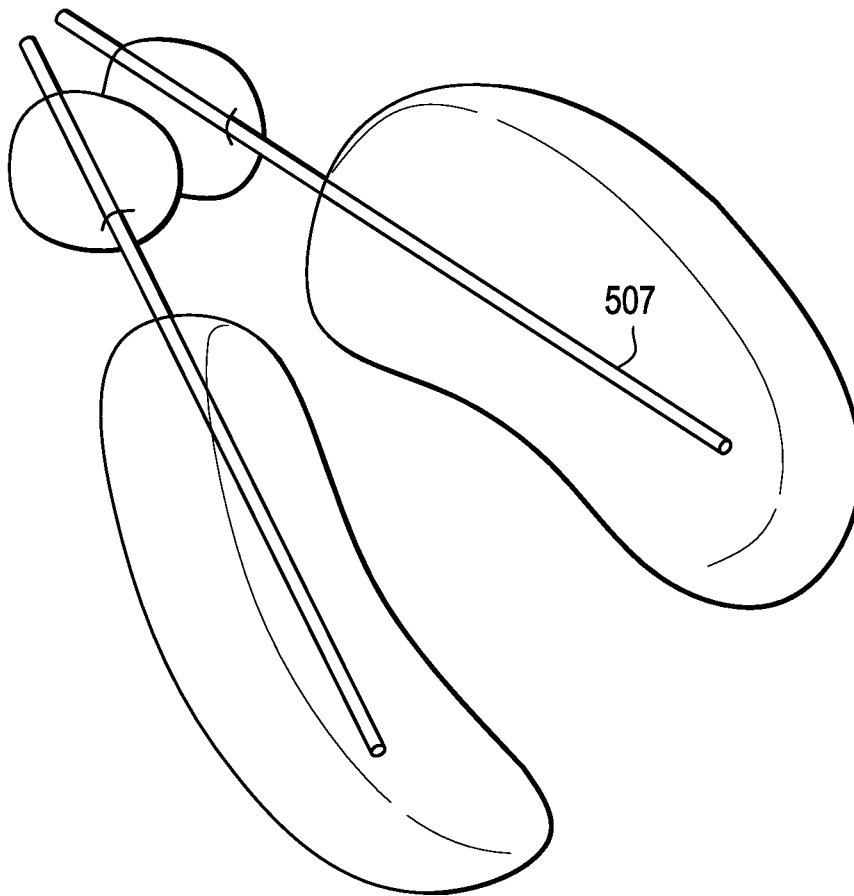


FIG. 16A

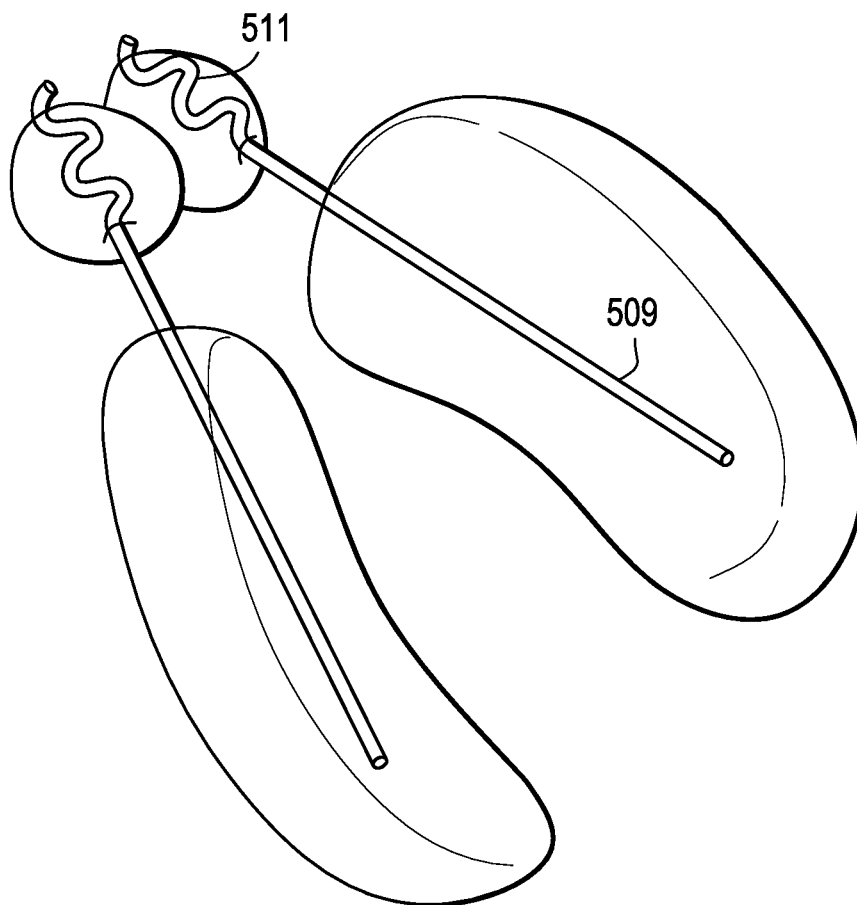


FIG. 16B

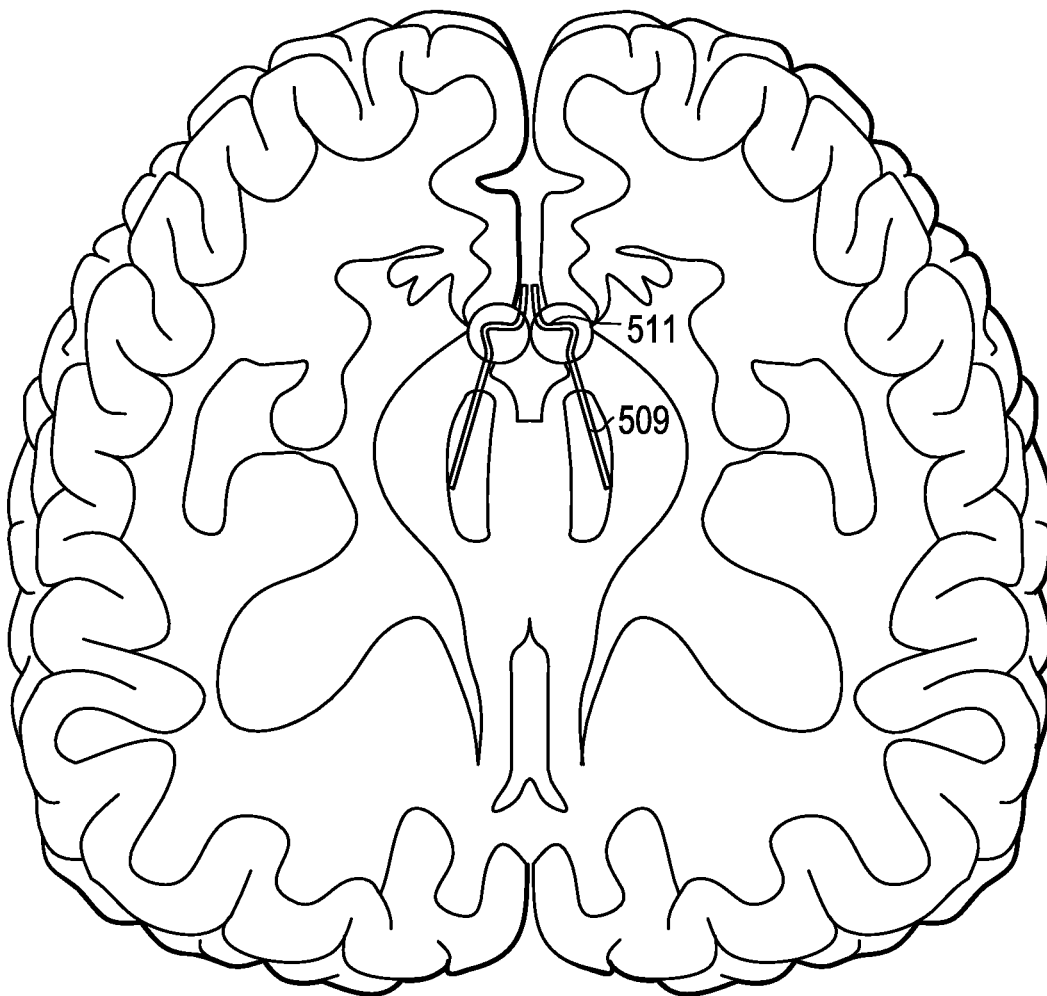


FIG. 17A

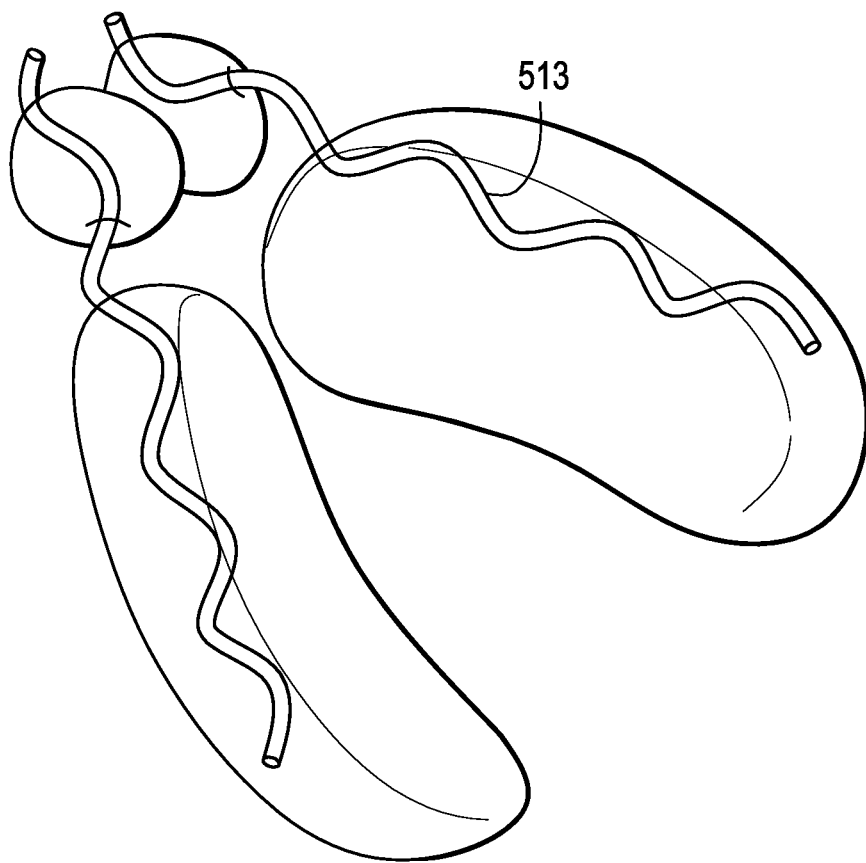


FIG. 17B

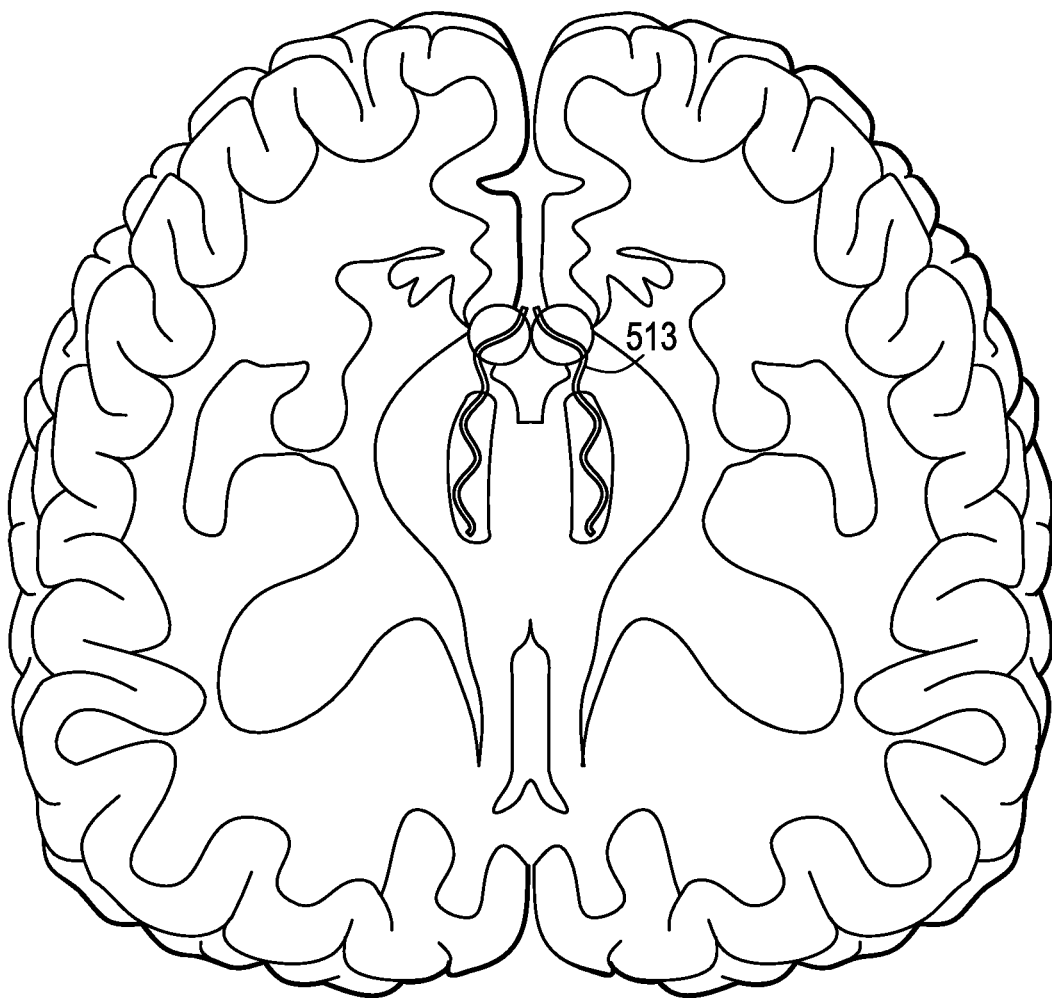


FIG. 18

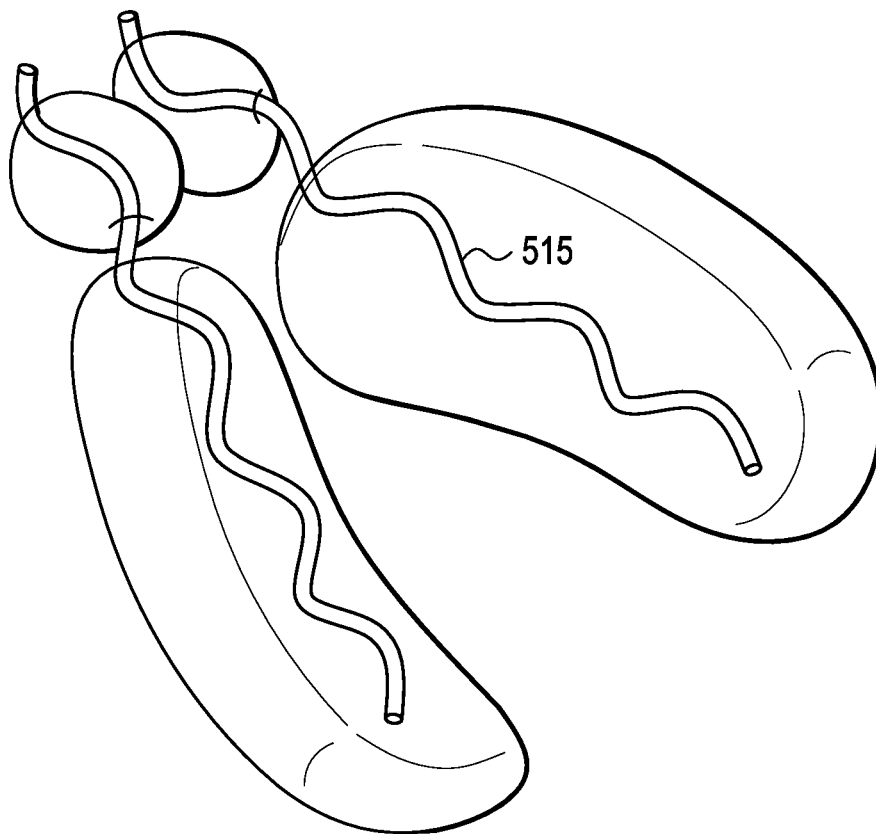


FIG. 19

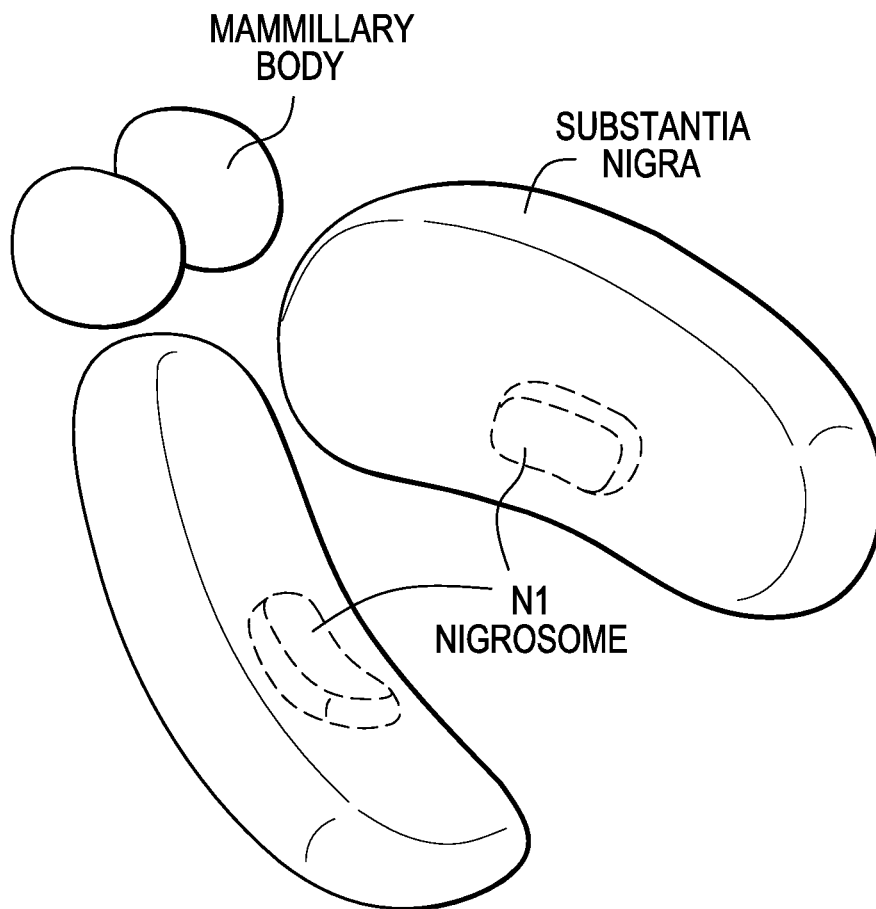


FIG. 20

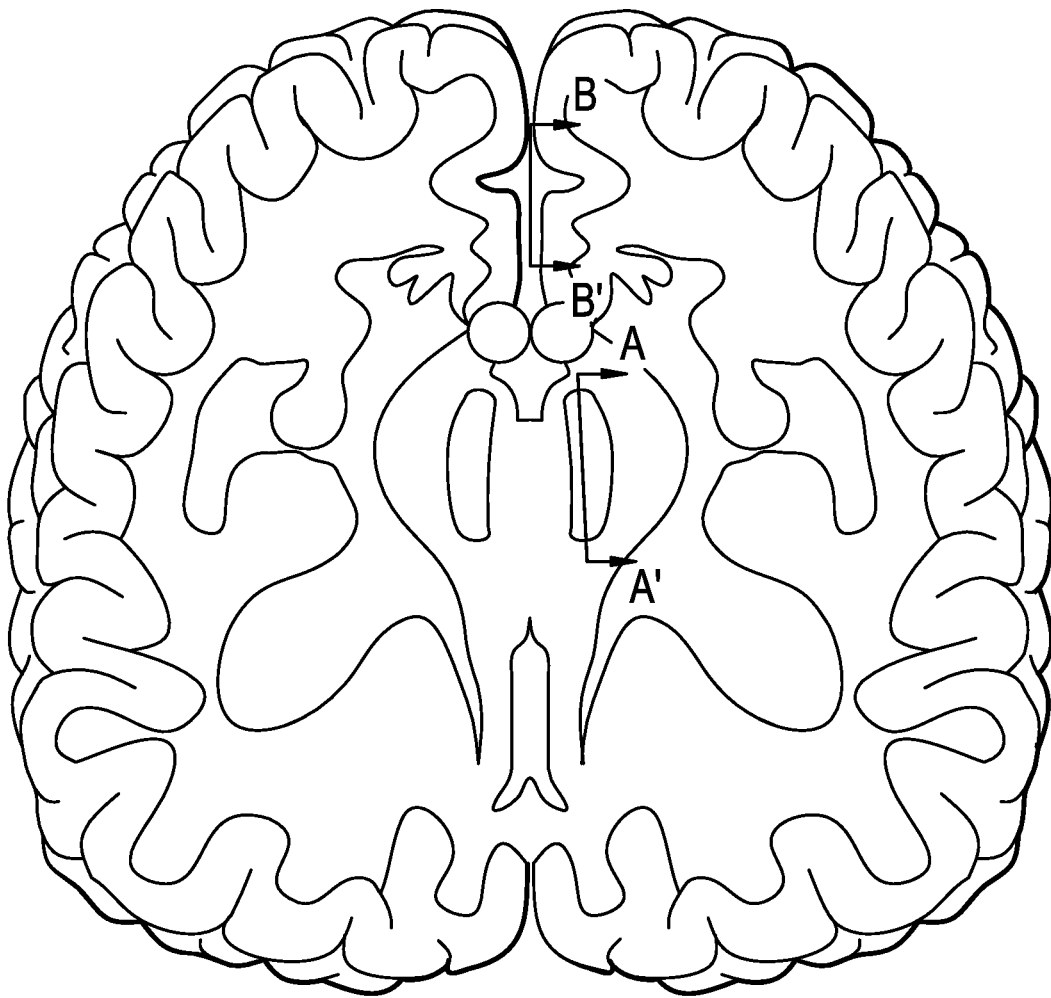


FIG. 21A

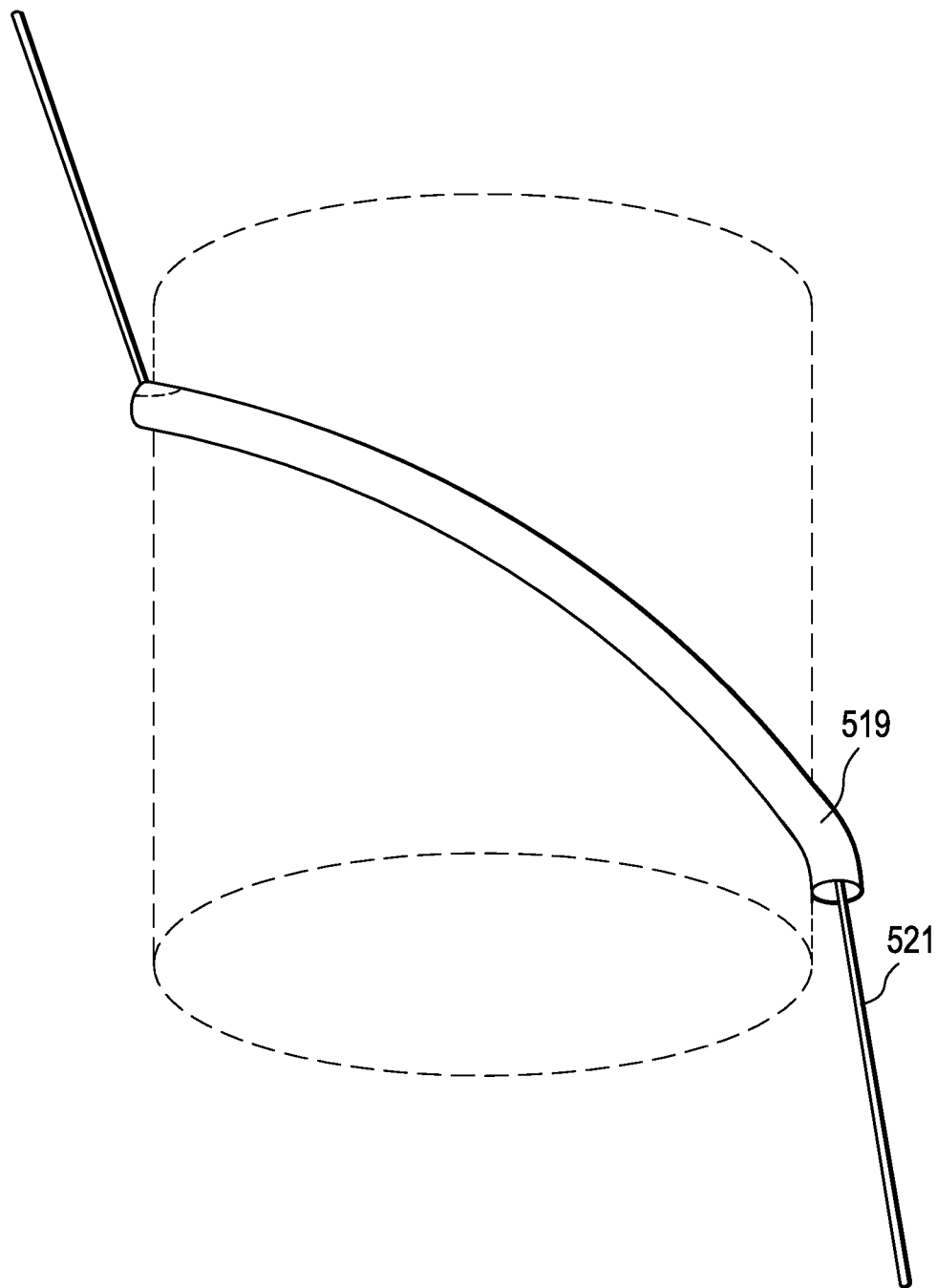


FIG. 21B

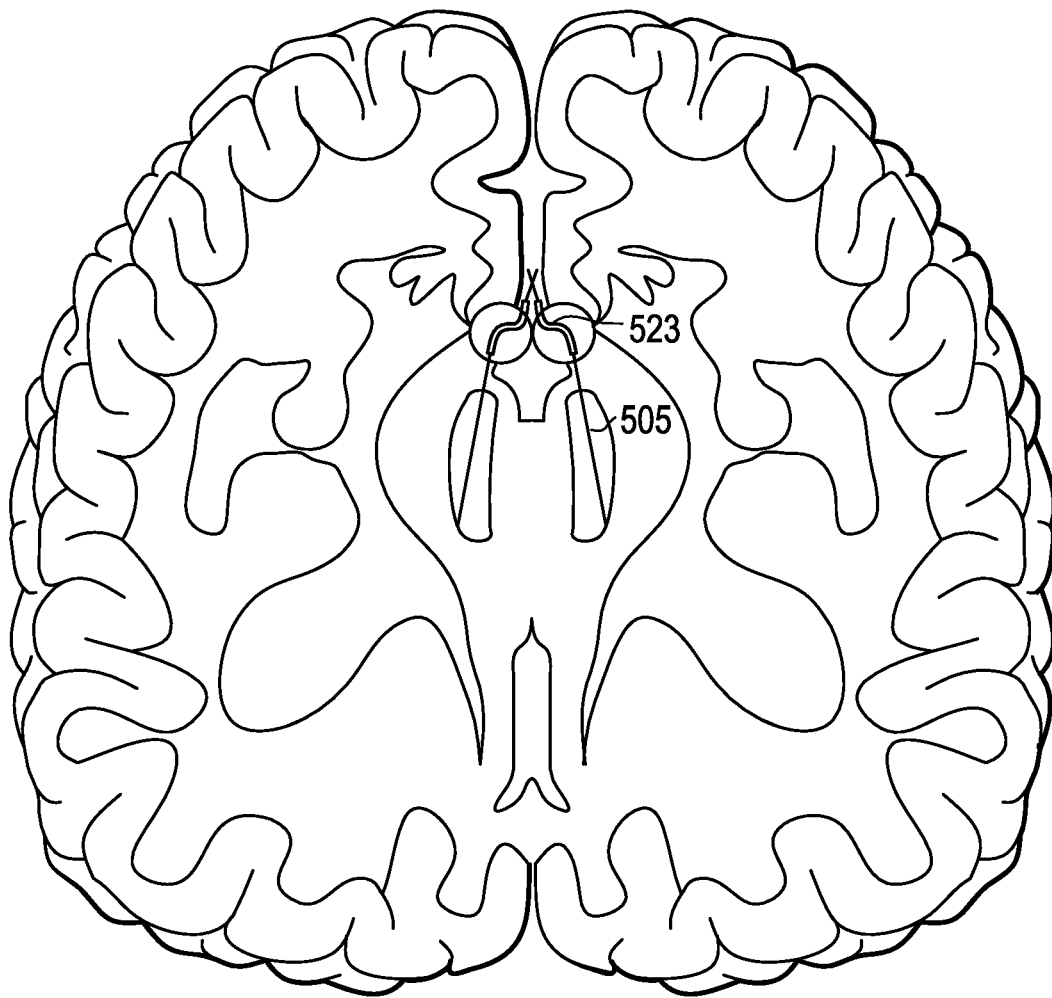


FIG. 22

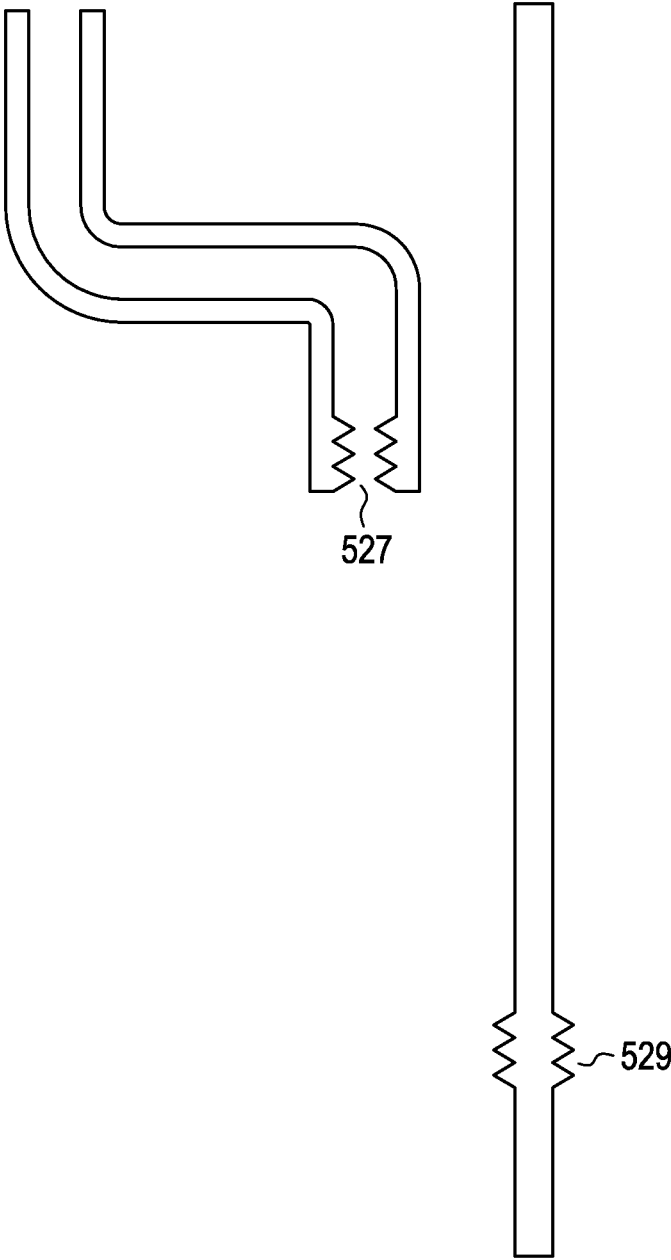


FIG. 23

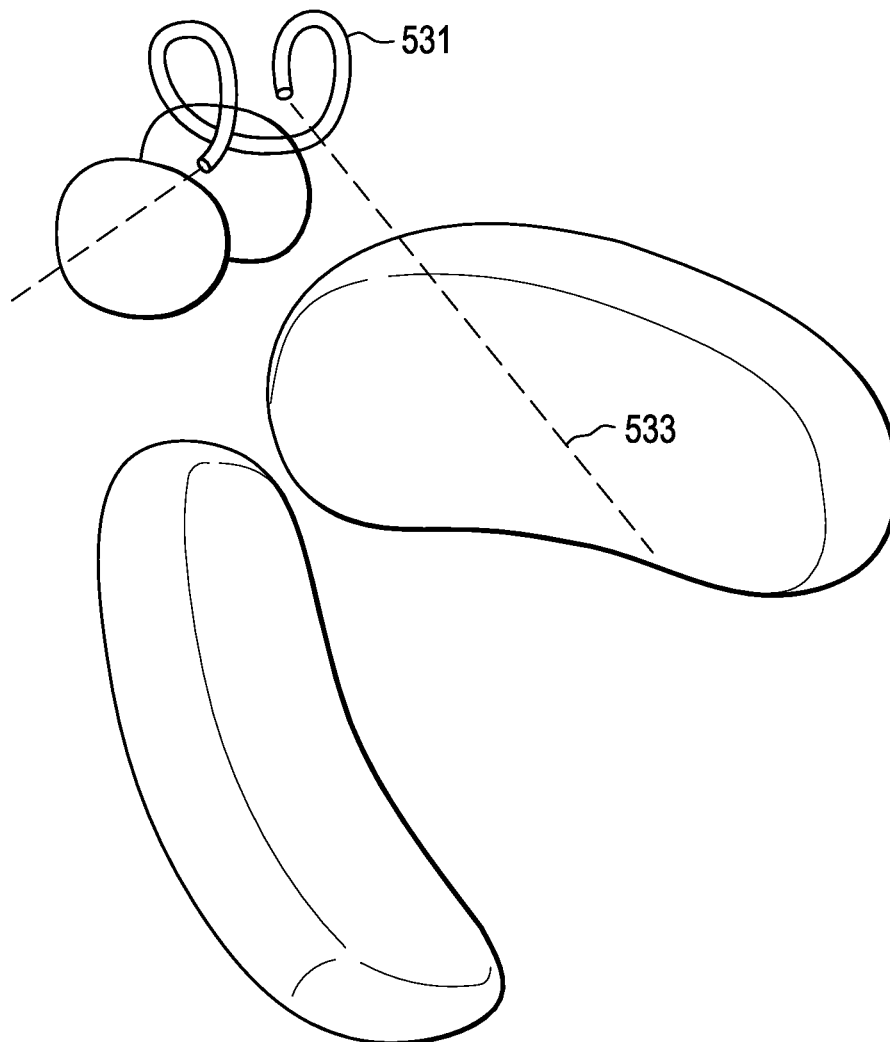


FIG. 24A

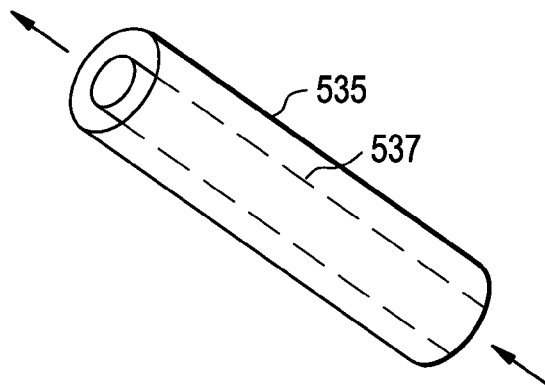


FIG. 24B

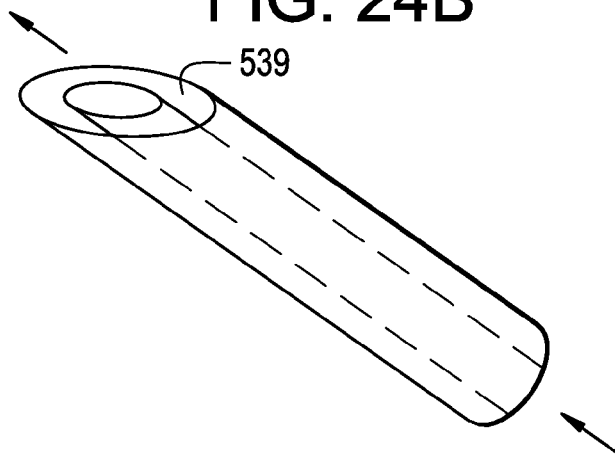


FIG. 24C

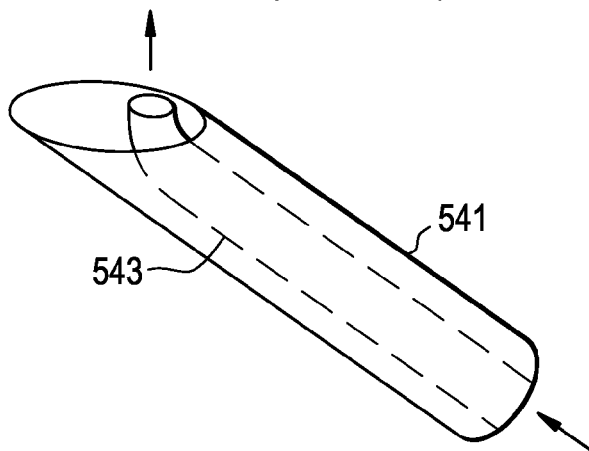


FIG. 25A

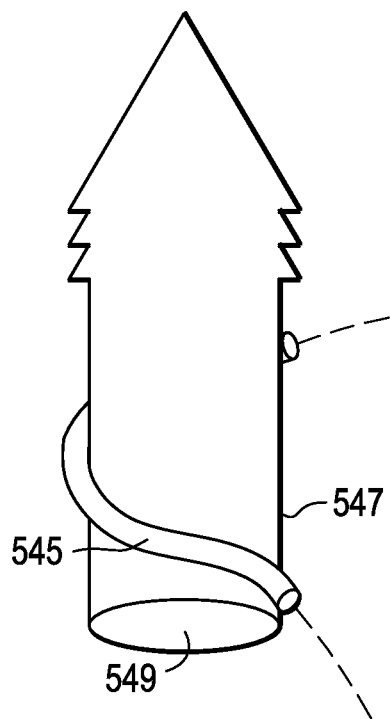


FIG. 25B

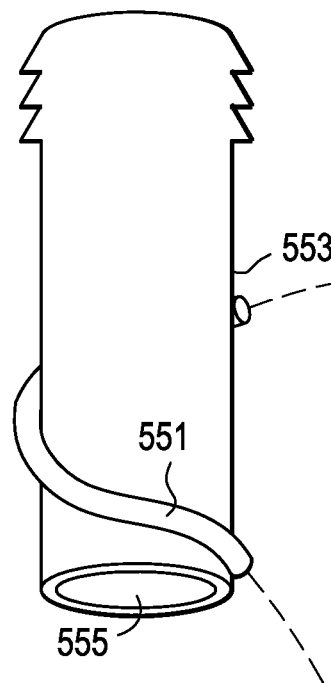


FIG. 25C

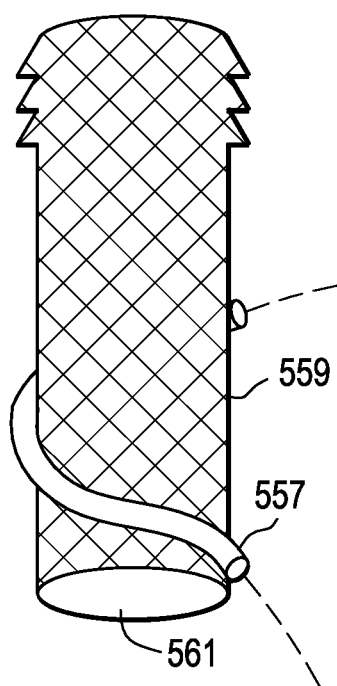


FIG. 25D

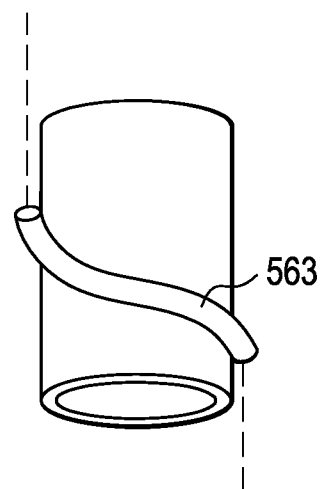


FIG. 26

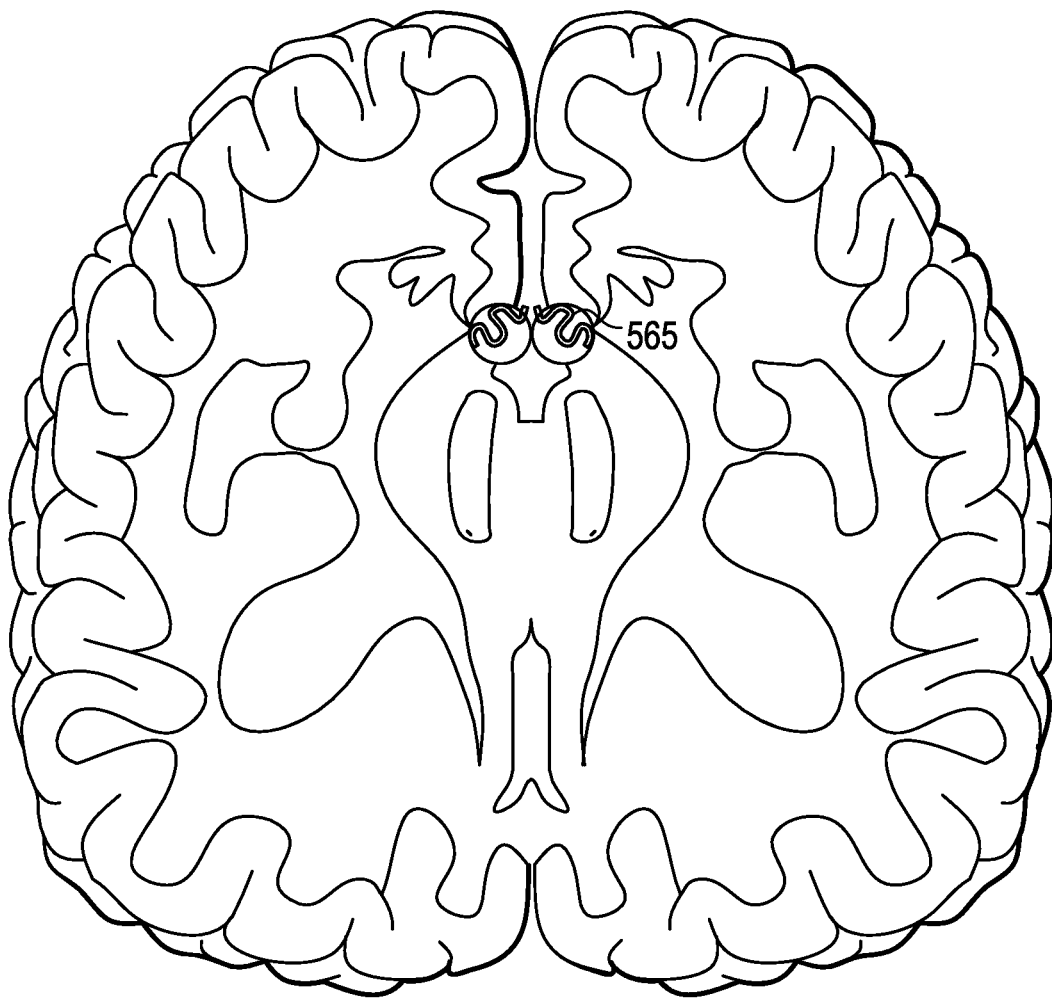


FIG. 27

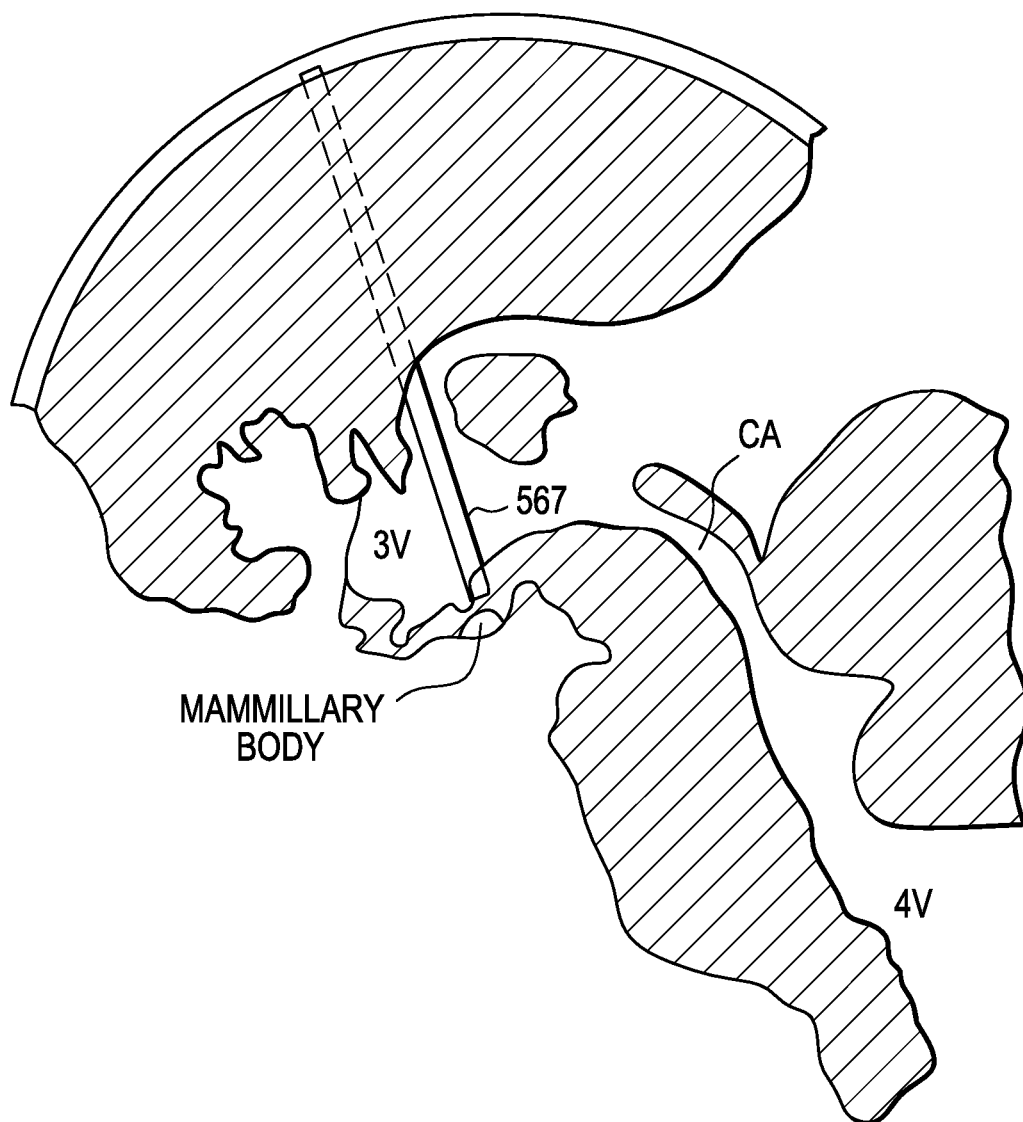


FIG. 28

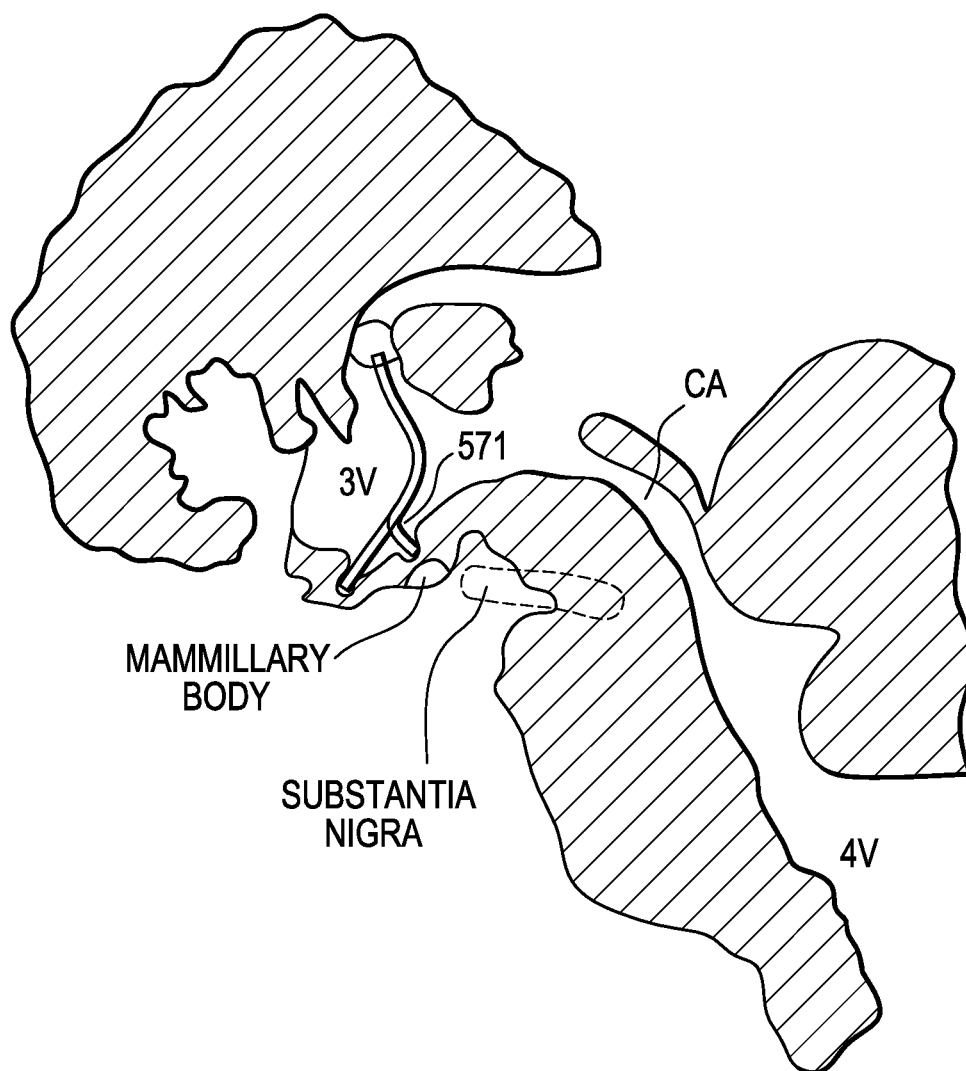
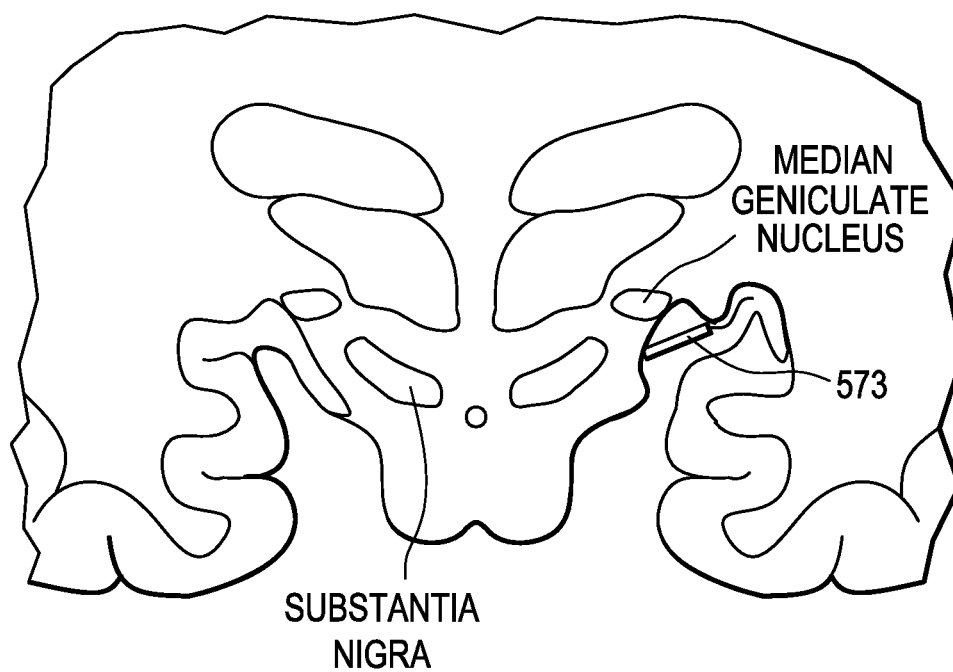


FIG. 29



1

ENDOSCOPIC DELIVERY OF RED/NIR LIGHT TO THE SUBVENTRICULAR ZONE

BACKGROUND OF THE INVENTION

Decreased neuronal energy production and increased oxidative stress are believed to be major components in the onset of Parkinson's Disease. It is believed that the substantia nigra contains high levels of iron, which helps catalyze oxygen to reactive oxygen species (ROS). The ROS then degrade dopamine-containing neurons. It is further believed that neurotoxins may be the cause of decreased neuronal energy output in the substantia nigra.

The literature describes the general use of anti-oxidants as potent neuroprotective agents for Parkinson's disease. For example, Dugan, *Parkin. Relat. Disord.*, 1002, July 7, (3) 243-6, describes the use of fullerene-based antioxidants as neuroprotective drugs. In addition, oral administration of ascorbic acid has been tried as a therapy for Parkinson's Disease. To date, however, none of the therapies involving systemic administration of anti-oxidants has been shown to be successful. One possible reason for their failure was their inability to cross the blood brain barrier.

SUMMARY OF THE INVENTION

This invention relates to an implantable diode that emits red/near infrared (NIR) light onto the substantia nigra as a treatment for Parkinson's Disease (PD).

It has been reported in the literature that near red/NIR light saves neurons that have been challenged by neurotoxins from apoptosis. In particular, Wong-Riley, *J. Biol. Chem.* Feb. 11, 2005, 280(6) 4761-71, e-pub Nov. 22, 2004, reports that irradiating neurons with 670 nm red light significantly reduced neuronal cell death induced by 300 mM KCN from 83.6% to 43.5%.

The general concept of repairing brain cells through red light irradiation is also well supported by the literature. Wollman, *Neurol. Res.* July 1998, 20(5) 470-2 reports that providing daily 3.6 J/cm² doses of red light from a He—Ne laser to cortex explants resulting in caused a significant amount of sprouting of cellular processes outgrowth. Wollman concludes that the irradiation induces neurite processes sprouting and improves nerve tissue recovery. Similarly, Wollman, *Neurol. Res.* 1996 Oct. 18(5) 467-70 reports the enhanced migration and massive neurite sprouting of cultured rat embryonal brain cells subject to an 8 minute dose of a 0.3 mW, He—Ne laser. Therefore, the red light of the present invention may further cause repair and regeneration of damaged dopaminergic cells.

Therefore, in accordance with the present invention, there is provided a method of treating a patient having Parkinson's Disease, comprising the steps of:

a) irradiating a portion of a substantia nigra of the patient with an effective amount of red/NIR light.

Also in accordance with the present invention, there is provided a method of treating a patient having Parkinson's disease, comprising the steps of:

- a) providing a fiber optic cable having a proximal end portion and a distal end portion;
- b) implanting the fiber optic cable into the patient's brain, and
- c) delivering red/NIR light through the fiber optic cable to irradiate a portion of a substantia nigra with an effective amount of red light.

2

Also in accordance with the present invention, there is provided a device for treating a patient having Parkinson's disease, comprising:

- a) a fiber optic cable having a proximal end portion and a distal end portion;
- b) an anchor attached to the proximal end portion of the fiber optic cable for fixing the fiber optic cable to the patient's skull.

Without wishing to be tied to a theory, it is believed that the therapeutic neuroprotective and neuroregenerative effects of red light described above may be due to a) an increase in ATP production in the irradiated neurons, and b) an increase in the activity of local anti-oxidant enzymes superoxide dismutase (SOD) and catalase.

It is believed that irradiating neurons in the brain with red/NIR light will likely increase ATP production from those neurons. Mochizuki-Oda, *Neurosci. Lett.* 323 (2002) 208-210, examined the effect of red light on energy metabolism of the rat brain and found that irradiating neurons with 4.8 W/cm² of 830 nm red/NIR light increased ATP production in those neurons by about 19%.

Without wishing to be tied to a theory, it is further believed that the irradiation-induced increase in ATP production in neuronal cell may be due to an upregulation of cytochrome oxidase activity in those cells. Cytochrome oxidase (also known as complex IV) is a major photoacceptor in the human brain. According to Wong-Riley, *Neuroreport*, 12:3033-3037, 2001, in vivo, light close to and in the near-infrared range is primarily absorbed by only two compounds in the mammalian brain, cytochrome oxidase and hemoglobin. Cytochrome oxidase is an important energy-generating enzyme critical for the proper functioning of neurons. The level of energy metabolism in neurons is closely coupled to their functional ability, and cytochrome oxidase has proven to be a sensitive and reliable marker of neuronal activity. Nonetheless, there is some doubt of an association between defects in cytochrome c oxidase in the substantia nigra and Parkinson's Disease. Itoh, *Mov. Disord.* January 1997, 12(1) 9-16.

By increasing the energetic activity of cytochrome oxidase, the energy level associated with neuronal metabolism may be beneficially increased. Indeed, the literature reports that red light reverses the inhibitory effects of neurotoxins upon cytochrome oxidase activity, leading to increased energy metabolism in neurons functionally inactivated by toxins. Wong-Riley *Neuroreport* 12(14) 2001:3033-3037 and Wong-Riley, *J. Biol. Chem.*, e-pub, Nov. 22, 2004.

According to Kamanli, *Cell Biochem. Func.* 2004, 22:53-57, catalase detoxifies hydrogen peroxide and converts lipid hydroperoxides into non-toxic alcohols, and is essential for the inhibition of inflammation related to the function of neutrophils.

Gonzalez, *Cell Biology Int'l*, 28(2004) 373-80, reports the effectiveness of catalase in enhancing the viability of PD cells in culture. In particular, Gonzalez reports that 50 U/ml catalase increased the in vitro viability of cerebellar granule cells exposed to MPP+ neurotoxin from about 50% to about 75%. Furthermore, it is believed that catalase is superior to the anti-oxidants recited in the prior art because it is not only an anti-oxidant, it is also neurotrophic towards CNS neurons. See Wallicke, *J. Neuroscience*, April 1986, 6(4), 1114-21.

Romm, *Biull. Eksp. Biol. Med.* 1986 October 102(10) 426-8 reports that laser irradiation of wounds results in a decreased chemiluminescence that is attributable to activation of catalase in the tissue fluid.

Therefore, it is believed that irradiating the substantia nigra with an effective amount of red/NIR light will therapeutically increase of the activity of catalase in the irradiated region,

thereby attenuating the deleterious effect of hydrogen peroxide upon the dopamine neurons in the substantia nigra.

According to Kamanli, supra, SOD catalyses dismutation of the superoxide anion into hydrogen peroxide.

SOD has been shown to be neuroprotective in a rat model of Parkinson's disease. Nakao *Nat. Med.* Mar. 1, 1995, (3) 226-231, reports that the survival of grafted dopaminergic neurons in transgenic rats designed to overexpress Cu/Zn SOD was about four times higher than those in control rats, and there was also a similar increase in functional recovery.

Vitreshchak, *Bull. Exp. Biol. Med.* 135(5) May 2003 430-432, reports that He—Ne irradiation of blood from Parkinson's patients produced a normalization of their Cu—Zn SOD activity. This means that patients having lower than normal levels of SOD increased their SOD to near normal levels. This paper further reports a decrease in the severity of PD (from 72 to 58 points) in these patients.

The literature repeatedly reports that red/NIR light irradiation of inactivated SOD increases its activity. For example, Vladimirov, *Biochemistry (Moscow)* 69(1) 2004, 81-90 provides a review including the photoreactivation of Cu—Zn SOD under He—Ne laser. Karu, *Laser Ther.* 1993, 5, 103-9 reports that reactive oxygen species in human blood were found to be suppressed after laser diode illumination at 660 nm, 820 nm, 880 nm and 950 nm. This affect has been attributed by other authors to the activation of SOD or catalase. Volotovskaia *Vopr Kurortol Zizioter Lech Fiz Kult* May-June 2003(3)22-5 reports that 632 nm He—Ne laser irradiation of blood has an anti-oxidant effect as shown by activation of SOD. Ostrakhovich *Vestn Ross Akad Med Nauk.* 2001(5) 23-7 reports that infrared pulse laser therapy of RA patients caused an increase in SOD activity. Gorbatenkova *Biofizika*, 1988 July-August 33(4) 717-9 reports that SOD that was inactivated by hydrogen peroxide was reactivated by a 450-680 nm red light laser. Vladimirov, *Free Rad. Biol. Med.* 1988, 5(5-6) 281-6 reports the inactivation of SOD by its incubation in a low pH 5.9 solution and its subsequent reactivation by helium-neon laser light. Catalase was found to be reactivated as well. Cho, *In Vivo*, September-October 2004, 18(5) 585-91 reports on the use of low level laser therapy (LLLT) to treat knee joints that have been induced with OA by injection of hydrogen peroxide. SOD was reported to increase about 40% in the OA group as compared to controls.

Therefore, it is believed that irradiating the substantia nigra with an effective amount of red light will therapeutically increase of the activity of SOD in the irradiated region, thereby attenuating the deleterious effect of superoxide anion upon the dopamine neurons in the substantia nigra.

Since red/NIR light is known to induce molecular vibrations (the basis of infrared spectroscopy), one could easily theorize that the use of IR light, particularly higher energy IR (e.g. shorter wavelengths 600-900 nm) could induce vibrations in the enzymes (proteins) of interest (such as catalase or SOD). It may be that the activity of these enzymes is inhibited or inactivated by weak intermolecular attractions, such as hydrogen bonding, Van der Waals, or ion chelation, causing sub-optimal protein conformations, and that the introduction of red light energy causes molecular vibrations sufficient to disrupt these weak forces, thereby allowing the enzyme to return to its active 3-D conformation upon relaxation. If such a mechanism of action was accurate, the adjunctive use of solutions to create slight changes in the local environment (pH, ionic strength, salivation) during the treatment could have profound effects upon the treatment, e.g. synergistic.

According to Leung, *Laser Surg. Med.* 31:283-288 (2002), nitric oxide enhances oxidative insult by reacting with superoxide anion to form a stronger oxidant, peroxynitrite, which

leads to mitochondrial dysfunction, DNA damage and apoptosis. As a result, excess NO has been implicated as a contributing factor to dopaminergic cell loss causing Parkinson's disease. Ebadi, *Antioxidants & Redox Signaling*, 5(3), 2003, pp. 319-335.

Leung, supra, investigated the effect of low energy red laser after stroke in rats, and found that red light can both suppress NO synthase activity (and upregulate the expression of TGF- β 1). In particular, Leung found that irradiating a portion of the rat's brain with a 660 nm red light (average power 8.8 mW, 2.64 J/cm²) reduced NOS activity up to about 80% over that in unirradiated stroke rats, and up to about 60% over the NOS activity in normal rats. Leung concluded that the main findings of the study was that low energy laser may be protective by suppressing the activity of NOS and upregulating the expression of TGF- β 1 in cerebral ischemia and reperfusion.

Without wishing to be theory, it is believed that irradiation of the substantia nigra portion of a Parkinson's brain will similarly therapeutically suppress NO synthase activity, thereby attenuating peroxynitrite activity.

DESCRIPTION OF THE FIGURES

FIG. 1 is a cross-section of an LED implant of the present invention implanted within the brain of a patient having Parkinson's Disease.

FIG. 2 is a cross-section of an implant of the present invention having a fiber optic cable and implanted within the brain of a patient having Parkinson's Disease.

FIG. 3 is a cross-section of an implant of the present invention having a tyned fiber optic cable and implanted within the brain of a patient having Parkinson's Disease.

FIGS. 4A-4B are cross-sections of a fiber optic implant of the present invention implanted within the brain of a patient having Parkinson's Disease.

FIG. 4C is a cross-section of a fiber optic implant of the present invention.

FIG. 5 is a cross-section of an implanted fiber optic implant irradiated by a light source.

FIG. 6 is a cross-section of an Rf source energized an LED implant of the present invention.

FIG. 7 is a cross-section of an LED implant of the present invention.

FIG. 8 is a schematic of electronics associated with an LED implant of the present invention.

FIG. 9 is a cross-section of a toothed LED implant of the present invention implanted within the brain of a patient having Parkinson's Disease.

FIGS. 10a and 10b disclose an optical wave guide seated in a pedunclopontine nucleus adjacent a substantia nigra.

FIG. 10c discloses coronal cross section of a human brain in which an optical wave guide is seated in a subthalamic nucleus adjacent a substantia nigra.

FIG. 11 discloses a horizontal cross section of an area surrounding a midbrain

FIG. 12 discloses a perspective view of a substantia nigra and a mammillary body.

FIG. 13 discloses a saggital cross section of a human brain showing a substantia nigra and mammillary body.

FIGS. 14a and 14b disclose a perspective and horizontal views of a straight fiber optic inserted horizontally into a substantia nigra from the third ventricle through the mammillary body.

FIG. 15 discloses a perspective view of a straight fiber optic inserted diagonally downward into a substantia nigra from the third ventricle through the mammillary body.

FIGS. 16a and 16b disclose a perspective and horizontal views of a fiber optic having a straight distal portion and a helical proximal portion inserted diagonally downward into a substantia nigra from the third ventricle through the mammillary body.

FIGS. 17a and 17b disclose a perspective and horizontal views of a helical fiber optic inserted horizontally into a substantia nigra from the third ventricle through the mammillary body.

FIG. 18 discloses a perspective view of a helical fiber optic inserted diagonally downward into a substantia nigra from the third ventricle through the mammillary body.

FIG. 19 discloses a perspective view of a substantia nigra containing an N1 nigrosome.

FIG. 20 discloses a horizontal cross section of an area surrounding a midbrain.

FIG. 21a discloses a semi-helical anchor tube extending for one-half a period.

FIG. 21b discloses a semi-helical anchor tube inserted into a mammillary body, and a flexible fiber optic running through the anchor tube into the substantia nigra.

FIG. 22 discloses an anchor tube and a fiber optic, each having a mating threadform.

FIG. 23 discloses a helical anchor tube inserted into a mammillary body, with a fiber optic (in ghost) running through it and into the substantia nigra.

FIGS. 24a-c disclose three anchor tubes having different exit geometries.

FIGS. 25a-d disclose various anchor tubes carried on the outer surfaces of cylindrical bodies.

FIG. 26 discloses a helical fiber optic inserted into just the mammillary body from the third ventricle.

FIG. 27 discloses a sagittal view of the human brain having an optical wave guide inserted into the third ventricle and bearing upon the floor of the third ventricle near the mammillary body.

FIG. 28 discloses a sagittal view of the human brain having a tripod instrument inserted onto the floor of the third ventricle.

FIG. 29 discloses a cross-section of the midbrain showing the medial geniculate nucleus adjacent the dorsal portion of the substantia nigra.

DETAILED DESCRIPTION OF THE INVENTION

Preferably, the red/NIR light of the present invention has a wavelength of between about 600 nm and about 1500 nm, more preferably between about 600 nm and about 1000 nm. In some embodiments, the wavelength of light is between 800 and 900 nm, more preferably between 825 nm and 835 nm. In this range, red light has not only a large penetration depth (thereby facilitating its transfer to the fiber optic and SN), but Wong-Riley reports that cytochrome oxidase activity is significantly increased at 830 nm, and Mochizuki-Oda reported increased ATP production via a 830 nm laser.

In some embodiments, the wavelength of light is between 600 and 700 nm. In this range, Wong-Riley reports that cytochrome oxidase activity was significantly increased at 670 nm. Wollman reports neuroregenerative effects with a 632 nm He—Ne laser.

In some embodiments, the light source is situated to irradiate adjacent tissue with between about 0.01 J/cm² and 20 J/cm² energy. Without wishing to be tied to a theory, it is believed that light transmission in this energy range will be sufficient to increase the activity of the cytochrome c oxidase around and in the target tissue. In some embodiments, the light source is situated to irradiate adjacent tissue with

between about 0.05 J/cm² and 20 J/cm² energy, more preferably between about 2 J/cm² and 10 J/cm² energy.

The present inventor are aware of at least two reports of very favorable effects of red/NIR light irradiation of neuronal cells at fluences of less than 1 J/cm². As discussed above, Byrnes, *Lasers Surg Med.* August 2005; 37(2):161-71 found that a significant (P<0.05) increase in brain derived neurotrophic factor (BDNF) and glial derived neurotrophic factor (GDNF) in the 0.2 J/cm² group in comparison to the non-irradiated group. Oron, *Photomed Laser Surg.* June 2007; 25(3):180-2 reports that normal human neural progenitor (NHNP) cells were grown in tissue culture and were treated by Ga—As laser (808 nm, 50 mW/cm², 0.05 J/cm²). They found that the quantity of ATP in laser-treated cells 10 minutes after laser application was 7513+/-970 units, which was significantly higher (p<0.05) than the non-treated cells, which comprised 3808+/-539 ATP units. In sum, Oron found that the neuronal ATP level was essentially doubled by LLLT. In addition, Byrnes, *Lasers Surgery Medicine*, March 2005, 36(3) 171-85 reports that dosages as low as 0.001 stimulate cellular activity (such as DNA, RNA and protein production, proliferation and motility). Therefore, it is believed that fluences as low as about 0.01 J/cm² (and possibly even about 0.001 J/cm²) will be effective in providing therapy to the pertinent nigral neurons of the Parkinson's patient.

In some embodiments, the light source is situated to produce about 10-90 milliwatt/cm², and preferably 7-25 milliwatt/cm².

In accordance with US Patent Publication 2004-0215293 (Eells), LLLT suitable for the neuronal therapy of the present invention preferably has a wavelength between 630-1000 nm and power intensity between 25-50 mW/cm² for a time of 1-3 minutes (equivalent to an energy density of 2-10 J/cm²). Eells teaches that prior studies have suggested that biostimulation occurs at energy densities between 0.5 and 20 J/cm². Wong-Riley, *J. Biol. Chem.* Feb. 11, 2005, 280(6), 4761-71 reports that fluences as high as 30 J/cm² appear to be effective in preventing cell death in neurons exposed to the mitochondrial poison KCN. In some embodiments, the preferable energy density of the present invention is between 0.1 and about 30 J/cm², more preferably between 0.5-20 J/cm², most preferably between 2-10 J/cm². In summary, a preferred form of the present invention uses red and near infrared (red/NIR) wavelengths of 630-1000, most preferably, 670-900 nm (bandwidth of 25-35 nm) with an energy density fluence of 0.5-20 J/cm², most preferably 2-10 J/cm², to produce photobiomodulation. This is accomplished by applying a target dose of 10-90 mW/cm², preferably 25-50 mW/cm² LED-generated light for the time required to produce that energy density.

It is further believed that red/NIR light irradiation of neurons will produce a significant upregulation in brain derived neurotrophic factor (BDNF) and glial derived neurotrophic factor (GDNF). Byrnes, *Lasers Surg Med.* August 2005; 37(2):161-71 reports that olfactory ensheathing OECs were purified from adult rat olfactory bulbs and exposed to 810 nm light (150 mW; 0, 0.2, or 68 J/cm²). Byrnes found that a significant (P<0.05) increase in BDNF, GDNF and collagen expression in the 0.2 J/cm² group in comparison to the non-irradiated and high dose groups.

Of note, it has been reported that the neuroprotective effects of red/NIR light can be effected by a single irradiation on the order of minutes. Wong-Riley, *J. Biol. Chem.* 2004, e-pub November 22, reports that irradiating neurons with 670 nm red light for only ten minutes results in neuroprotection. Similarly, Wong-Riley *Neuroreport* 12(14) 2001:3033-3037 reports that a mere 80 second dose of red light irradiation of neuron provided sustained levels of cytochrome oxidase

activity in those neurons over a 24 hour period. Wong-Riley hypothesizes that this phenomenon occurs because “a cascade of events must have been initiated by the high initial absorption of light by the enzyme”.

Therefore, in some embodiments of the present invention, the therapeutic dose of red light is provided on approximately a daily basis, preferably no more than 3 times a day, more preferably no more than twice a day, more preferably once a day.

In some embodiments, the red light irradiation is delivered in a continuous manner. In others, the red light irradiation is pulsed in order to reduce the heat associated with the irradiation. Without wishing to be tied to a theory, it is believed that pulsed light may be more effective in achieving the vibratory oscillation of the catalase and SOD molecules.

In some embodiments, red light is combined with polychrome visible or white light

Thus, there may be a substantial benefit to providing a local radiation of the substantia nigra with red laser light. The red light can be administered in a number of ways:

- 1) By implanting near the skull an implant having a red light LED, an antenna and a thin fiber optic terminating at the substantia nigra, and telemetrically powering the LED via an external antenna to deliver red light through the fiber optic to the substantia nigra.
- 2) By placing a fiber optic having a proximal light collector at the interior rim of the skull and running it to the substantia nigra, and then irradiating the proximal end via an external red light source. Red light can penetrate tissue up to about one cm, so it might be able to cross the skull and be collected by the collector.
- 3) By implanting a red light LED in the skull, and powering the LED via an internal battery.

In each case, there is produced an effective amount of local red or infrared irradiation around the substantia nigra. This light would then increase local ATP production, and enhance SOD and catalase activity, thereby increasing the metabolism in and reducing the oxidative stress upon the substantia nigra.

Now referring to FIG. 1, there is provided an implant for treating Parkinson's disease comprising:

- a) a Red/NIR Light emitting diode (LED) **11**, and
- b) an antenna **21** in electrical connection with the LED.

In use, the surgeon implants the device into the brain of the patient so that the device is adjacent to a portion of the substantia nigra. The Red light produced by the implant will then irradiate that portion of the substantia nigra.

In order to protect the active elements of the device from cerebrospinal fluid (“CSF”), in some embodiments, and again referring to FIG. 1, the Red light LED is encased in a casing **25**. This casing both protects the LED components from the CSF, and also prevents the LED components from eliciting a violent immune reaction. In some embodiments, the casing is made of a Red/NIR light transparent material. The Red/NIR light transparent material may be placed adjacent the LED component so that Red/NIR Light may be easily transmitted therethrough. In some embodiments, the transparent casing is selected from the group consisting of silica, alumina and sapphire. In some embodiments, the light transmissible material is selected from the group consisting of a ceramic and a polymer. Suitable red light-transmissible ceramics include alumina, silica, CaF, titania and single crystal-sapphire. Suitable light transmissible polymers are preferably selected from the group consisting of polypropylene and polystyrenes.

In some embodiments, it may be desirable to locate the light emitting portion of the implant at a location separate from the LED, and provide a light communication means between the two sites. The light communication means may

include any of a fiber optic cable, a wave guide, a hollow tube, a liquid filled tube, and a light pipe.

In some embodiments, an implanted light communication means (or “optical wave guide”) is used to deliver photonic energy from the light source to a location within the brain. The optical wave guide can be embodied as an optical fiber, or internally-reflective tube (or “light pipe”). At its distal end, it may have a diffusion/diffraction surface(s), an optical lens and/or a mirror system, etc. or a combination of these elements.

In some embodiments, the optical wave guide is a light pipe. In one embodiment, the light pipe is a truncated form of the Flexible Light Pipe FLP 5 Series, marketed by Bivar Inc., which is a flexible light pipe that is 12 inches long and 2 mm in diameter, and has an outer tubing of fluorinated polymer TFE.

In some embodiments, the optical wave guide is a coiled sheet or convoluted surface that guides optical energy (light) from a source to a final target (in this case, a tissue or anatomical region of the brain, the substantia nigra). The benefit of a hollow optical wave guide is the decreased amount of light energy being absorbed by the material conduit. This benefit is mitigated by optical inefficiencies due to imperfect reflectance, but light attenuation by absorption will be greatly reduced in a hollow internally reflecting optical wave guide.

Silicone might also be used as the core and/or cladding of an optical fiber as long as the materials have different optical refractive indices. Those practiced in the art will appreciate how to manufacture silicone cores with silicone cladding.

Alternatively, a traditional optical material like glass or clear acrylic can be used as the optical wave guide core with silicone cladding that also serves as a biological boundary to impart overall device biocompatibility.

In some embodiments in which an optical wave guide is used, the distal end of the optical wave guide is a diffuser. Typically, the diffuser has a) a bulk phase comprising a light transmissive material and b) a dispersed phase comprising a light reflective material.

In some embodiments in which a fiber optic is used, the distal end of the fiber optic has a diffuser attached thereto.

In some embodiments in which a light pipe is used, the distal end of the light pipe has a diffuser or fiber optic cable attached thereto.

In some embodiments in which a fiber optic is used, the distal end of the fiber optic has a diffuser attached thereto.

Now referring to FIG. 2, there is provided an implant **1** for treating Parkinson's disease comprising:

- a) a Red/NIR Light emitting diode (LED) **11**,
- b) an antenna **21** in electrical connection with the LED, and
- c) a fiber optic cable **31** adapted to transmit Red light, the cable having a proximal end **33** connected to the LED and a distal end portion **35**.

Such a configuration would allow the distal end of the fiber optic to be located deep within the patient's brain near the substantia nigra and yet have the light source and associated components located near or in the skull in a less sensitive region. This configuration allows easier access to the light/controller should the need arise for service or maintenance, and also allow for more efficient transdermal energy transmission. Moreover, by using a hollow tube with reflective internal surfaces, light and therapeutic fluids (such as a fibroblast graft) could be delivered to the implanted device. The light source/controller implanted near the patient's skull could also be a simple, hollow chamber made to facilitate the percutaneous access described above. The advantages and benefits of this system include:

- a) further removal from the deep site of the functional implant, thereby reducing risk of contamination of the deeper site by percutaneous access;
- b) easier precutaneous access by being closer to the skin surface and having a larger surface area or target to access with the needle;
- c) a larger volume could hold more therapeutic fluid to provide a longer duration of activity.

In use, the surgeon implants the device into the brain of the patient so that the antenna is adjacent the cranium bone and the distal end of the fiber optic cable is adjacent to the substantia nigral region of the brain.

In some embodiments, the proximal end portion of the fiber optic cable is provided with a cladding layer **41** of reflective material to insure that Red light does not escape the cable into untargated regions of brain tissue.

In some embodiments, the distal end portion of the fiber optic cable includes a plurality of fiber optic tynes **51** extending from the cable (as shown in FIG. **3**). Since each of these tynes transmits Red light into brain tissue, the provision of tynes increases the volume of brain tissue that can be irradiated.

In some embodiments, the tynes located at distal end portion of the fiber optic cable are placed around the substantia nigra.

Because long wavelength red light can penetrate up to many centimeters, it might be advantageous to transcutaneously deliver the light the fiber optic. Now referring to FIGS. **4a-4c**, in one embodiment, a fiber optic **401** having a proximal light collector **403** is placed at the interior rim of the skull and the distal end portion **405** of the cable (which is unclad) is run to the substantia nigra. Red light can then be delivered transcutaneously from a probe **415** to the collector **403**, which will then transport the light to the substantia nigra.

In some embodiments, as in FIG. **4c**, the collector **403** has a porous osteoconductive collar **407** for integrating with the bone in the skull. The collector may comprise a funnel-shaped mirror **409** (made of titanium) that connects to the fiber optic cable **401** and is filed with a red light-transparent material **411** such as silica.

To enhance the propagation of light emitted from the end of the fiber, a lens could be placed at the distal end of the fiber to spread the light, or a diffuser such as a small sheet or plate of optical material could be used to create more surface area. Alternatively, one could create a series of lateral diffusers, such as grooves or ridges, along the distal portion of end of the fiber to spread light out from 360 degrees perpendicular to the axis of the fiber, as well as emanating directly out from the end of the fiber.

Now referring to FIG. **5**, there is provided an implant having an external light source. The externally based-control device has a light source **101** for generating light within the device. The light generated by this source is transmitted through fiber optic cable **103** through the patient's skin **S** to an internally-based light port **109** provided on the proximal surface **110** of the implant **201**. The light port is adapted to be in light-communication with fiber optic cable **221** disposed upon the distal surface **203** surface of the implant. The tynes **223** disposed upon the distal portion **224** of the fiber optic cable receive the light and transmit the light to the adjacent brain tissue.

Now referring to FIG. **6**, there is provided an exemplary Red light unit having an internal light source. Externally based-control device **222** has an RF energy source **224** and an antenna **230** for transmitting signals to an internally-based antenna **232** provided on the prosthesis. These antennae **230**, **232** may be electro-magnetically coupled to each other. The

internal antenna **232** sends electrical power to a light emitting diode (LED) **234** disposed internally on the implant in response to the transmitted signal transmitted by the external antenna **230**. The light generated by the LED travels across light transparent casing **25** and into the brain tissue BT.

In some embodiments, and now referring to FIG. **7**, the prosthesis having an internal light source further contains an internal power source **300**, such as a battery (which could be re-chargeable), which is controlled by an internal receiver and has sufficient energy stored therein to deliver electrical power to the light source **234** in an amount sufficient to cause the desired light output.

When the implant is coupled with external energy, power can be transmitted into the internal device to re-charge the battery.

In some embodiments, the light generated by the implant is powered by wireless telemetry integrated onto or into the implant itself. In the FIG. **6** embodiment, the LED **234** may comprise a radiofrequency-to-DC converter and modulator. When radiofrequency signals are emitted by the external antenna **230** and picked up by the internal antenna **232**, these signals are then converted by the receiver (not shown) into electrical current to activate the light source of the PCO unit.

In one embodiment, the implant may have an internal processor adapted to intermittently activate the LED.

In some embodiments, the telemetry portion of the device is provided by conventional, commercially-available components. For example, the externally-based power control device can be any conventional transmitter, preferably capable of transmitting at least about 40 milliwatts of energy to the internally-based antenna. Examples of such commercially available transmitters include those available from Microstrain, Inc. Burlington, Vt. Likewise, the internally-based power antenna can be any conventional antenna capable of producing at least about 40 milliwatts of energy in response to coupling with the externally-generated Rf signal. Examples of such commercially available antennae include those used in the Microstrain Strainlink™ device. Conventional transmitter-receiver telemetry is capable of transmitting up to about 500 milliwatts of energy to the internally-based antenna.

In some embodiments, and now referring to FIG. **8**, the implant includes a light emitting diode (LED) **234** built upon a base portion **3** of the implant, along with the required components to achieve trans-dermal activation and powering of the device. These components can include, but are not limited to, RF coils **301**, control circuitry **303**, a battery **305**, and a capacitor. Such a device could be capable of intermittent or sustained activation without penetrating the skin, thereby avoiding trauma to the patient and/or risk of infection from skin-borne bacteria. As shown above, the accessory items needed to power and control the LED may be embedded within the implant. However, they could also be located on the surface(s) of the implant, or at a site adjacent to or near the implant, and in communication with the implant.

In some embodiments, the light source is provided on the implant and is adapted to be permanently implanted into the patient. The advantage of the internal light source is that there is no need for further transcutaneous invasion of the patient. Rather, the internally-disposed light source is activated by either a battery disposed on the implant, or by telemetry, or both. In some embodiments of the present invention using an internal light source, the light source is provided by a bioMEMs component.

Because use of the present invention may require its repeated activation by Rf energy, it would be helpful if the user could be guaranteed that the implant remained in the

same place within the skull. Accordingly, in some embodiments, and now referring to FIG. 9, the device of the present invention comprises anchors 91, preferably projecting from the casing 25. Preferably, the anchors are placed on the proximal side of the device, adjacent the antenna 21. In this position, the anchor may be inserted into the bone of the skull S, thereby insuring its position.

It is anticipated that the present invention would be useful in treating neurodegenerative diseases such as Parkinson's Disease, SRO Syndrome, progressive Supranuclear Palsy, parkinsonism and Alzheimer's Disease.

It is anticipated that functional benefits following red light irradiation are site-specific. In some embodiments, the fiber optic is placed to irradiate the dorsal striatum; the lateral striatum; the caudate nucleus; the putamen; the posterior putamen; the anterior putamen/caudate nucleus complex.

In some embodiments, the fiber optic is placed to irradiate the substantia nigra. Therefore, the fiber optic may be placed within about an 4 mm of the substantia nigra. The surgeon may access the substantia nigra through the brain parenchyma using stereotactic MRI guidance. As it is desirable to use a flexible material as the fiber optic in order to reduce migration, the distal end of the fiber optic may be placed near the substantia nigra with the help of a relatively stiff introducer cannula.

In some embodiments, the patient can receive a unilateral fiber optic, while in other the patient can receive bilateral fiber optic. In some embodiments, a plurality of cables is used to deliver light to each target region.

In some embodiments, a red light source or red light collector and the proximal end of the fiber optic are placed in the chest. This allows the surgeon to conduct maintenance activity on an implanted light source without having to re-open the cranium. In addition, location within the chest also lessens the chances of surface erosion.

In some embodiments, electrical stimulation of a portion of the brain (other than the substantia nigra) is carried out. In some embodiments, the stimulation is accomplished with a separate conductive wire. In others, the stimulation is in part accomplished by painting a conductive strip upon a longitudinal surface of the fiber optic cable.

Without wishing to be tied to a theory, it is believed that red/NIR light emanating from a fiber optic can safely and therapeutically irradiate a sphere of midbrain tissue having a radius of at least about 5 mm, preferably at least about 10 mm. There are at least two literature references that support this belief. First, Angell-Petersen, *J. Biomed. Optics*, 12(1), 014003-1-9 (January February 2007) studied the penetration depth of NIR light in normal and tumorous brain tissue. FIG. 4 of Angell-Petersen reported that a fiber optic inserted in brain tumor tissue will produce a fluence of 30 units at a radius of about 1 mm, a fluence of about 10 units at a radius of about 2 mm, a fluence of about 0.1 units at a radius of about 5 mm, and a fluence of about 0.01 units at a radius of about 9 mm. Angell-Petersen reports a 1000-fold decrease in intensity at 10 mm. Extrapolating from FIG. 4 of Angell-Petersen provides a fluence of about 0.001 units at a radius of about 12 mm.

Second, Oron, *Stroke*, 37, 2006, 2620-2624, reported that transcranial NIR irradiation of a rat brain with about 0.9 J/cm² of NIR light at the brain surface caused the proliferation of cells of the subventricular zone (SVZ). Because Oron discloses (in a figure) the SVZ to be located about 5 mm beneath the surface of the rat brain, it may be reasonably concluded that 0.9 J/cm² NIR light penetrated at least 5 mm in therapeutic quantities.

Therefore, using Angell-Petersen as a guide, it is believed that a fiber optic tip implanted about 1 mm adjacent the substantia nigra can produce a fluence of 30 J/cm² about 1 mm from the edge of the SN, a fluence of about 10 J/cm² at the edge of the SN, a fluence of about 0.1 J/cm² about 4 mm from the edge of the SN, a fluence of about 0.01 J/cm² about 8 mm from the edge of the SN, and a fluence of about 0.001 J/cm² about 11 mm from the edge of the SN. This latter distance corresponds to nearly 70% of the substantial length of the typical substantia nigra

In some embodiments, a fiber optic is placed in the lateral ventricle and irradiates the cells of the subventricular zone (SVZ) with therapeutic amounts of red/NIR light. SVZ cells are neural progenitor cells that can facilitate neurogenesis within the substantia nigra by either migrating to the substantia nigra or by emitting neurotrophins such as GDNF and BDNF. Shan, *Stem Cells*, 2006, 24:1280-7 reports on the enhanced de novo neurogenesis in the SN in a mouse PD model, and speculates that the proliferation of neural progenitor cells is due to their migration from the SVZ. In some embodiments, the SVZ fiber optic is used by itself. In other embodiments, the SVZ fiber optic is used in conjunction with a fiber optic that irradiates the substantia nigra.

Therefore, in accordance with the present invention, there is provided a method of treating a patient having a neurodegenerative disease, comprising the steps of:

- a) providing an optical wave guide having a proximal end portion and a distal end portion;
- b) endoscopically implanting the distal end portion of the optical wave guide into a lateral ventricle, and
- c) delivering light through the optical wave guide to irradiate at least a portion of a subventricular zone with an effective amount of red/NIR light.

Although the present invention deals mainly with treating Parkinson's Disease, the present inventors are also aware that it has been reported that manipulating the stem cells of the SVZ may also be useful in treating stroke, traumatic brain injury (TBI), and multiple sclerosis. In particular, Nait-Oumesmar, *Proc Natl Acad Sci USA*, 2007 Mar. 13; 104(11): 4694-9 reports that activation of gliogenesis in the SVZ occurs in human MS and suggests the mobilization of SVZ-derived early glial progenitors to periventricular lesions, where they could give rise to oligodendrocyte precursors. Nait-Oumesmar concludes that these early glial progenitors could be a potential target for therapeutic strategies designed to promote myelin repair in MS.

Therefore, also in accordance with the present invention, there is provided a method of treating multiple sclerosis, comprising the steps of:

- a) providing a patient with multiple sclerosis having periventricular lesions, and
- b) irradiating at least a portion of a subventricular zone of the patient with an effective amount of red/NIR light.

Therefore, also in accordance with the present invention, there is provided a method of treating stroke, comprising the steps of:

- a) providing a stroke patient, and
- b) irradiating at least a portion of a subventricular zone of the patient with an effective amount of red/NIR light.

Therefore, also in accordance with the present invention, there is provided a method of treating traumatic brain injury, comprising the steps of:

- a) providing a patient having a traumatic brain injury, and
- b) irradiating at least a portion of a subventricular zone of the patient with an effective amount of red/NIR light.

Bernier, *Neurosci. Res.* 37 (2000) 67-78 at 70 reports the existence of SVZ progenitor cells in the ventral (hypotha-

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lamic) portion of the third ventricle. Accordingly, in some embodiments, red/NIR light is therapeutically shined upon the ventral (hypothalamic) portion of the third ventricle of the Parkinson's patient in order to stimulate SVZ cells.

Therefore, in accordance with the present invention, there is provided a method of treating a patient having a neurodegenerative disease, comprising the steps of:

- a) providing an optical wave guide (or LED) having a proximal end portion and a distal end portion;
- b) endoscopically implanting the distal end portion of the optical wave guide (or LED) into a third ventricle, and
- c) delivering light through the optical wave guide (or LED) to irradiate at least a portion of a subventricular zone of a hypothalamic portion of the third ventricle with an effective amount of red/NIR light.

In some embodiments wherein the substantia nigra is effectively irradiated, the distal end of the fiber optic is seated in the pedunculo pontine nucleus (PPN) through stereotactic guidance. The procedure for seating the fiber optic in the PPN is disclosed in Stefani, *Brain*, 2007, 130(6), 1596-1607 ("Stefani"). It has been noted by the present inventors that the stereotactic path to the PPN disclosed in Stefani runs essentially directly adjacent and parallel to a broad side of the substantia nigra. See color figures of FIG. 1 of Stefani and 1B in particular). If a light diffusing fiber optic is used in the place of the Stefani electrode, the distal 5 mm of such a fiber optic **501** can readily illuminate a broad portion of the substantia nigra. See FIGS. **10a** and **10b** herein. Thus, the seating of the fiber optic directly adjacent the SN may be safely accomplished by simply using the conventional stereotactic procedure for PPN-electrode placement to seat a fiber optic in the PPN. In this embodiment, the fluence of the light may be such that the light may provide an inhibitory dose (i.e., which, in some references, such as Ells, is over about 20 J/cm²) within the PPN and a stimulating dose (between about 0.01 J/cm² and 10 J/cm²) to the lateral portion of the substantia nigra. Preferably, the fiber optic is placed so that it is adjacent the middle third of the substantia nigra.

In some embodiments wherein the substantia nigra is effectively irradiated, the distal end of the fiber optic is seated in the subthalamic nucleus (STN) through stereotactic guidance. The STN is located in the midbrain substantially adjacent to the upper and lateral portion of the substantia nigra. In this embodiment, the fluence of the light is such that the light may provide an inhibitory dose (i.e., over about 20 J/cm²) within the STN and a stimulating dose (between about 0.01 J/cm² and 10 J/cm²) to the lateral portion of the substantia nigra. Conventional stereotactic procedures for seating DBS electrodes in the STN may be used. FIG. **10c** is a coronal section showing a fiber optic **503** streotactically embedded in the STN.

In some embodiments wherein the substantia nigra is effectively irradiated, the distal end of the fiber optic is seated in the substantia nigra (SN) through stereotactic guidance. In some embodiments thereof, the path used to stereotactically place an electrode in the STN is extended and used to place the distal end of the fiber optic is seated in the substantia nigra (SN). It has been noted by the present inventors that the stereotactic paths to the STN disclosed in Welter, *Arch. Neurol.* 2004: 61:89-96 (FIG. 1), and Stefani (FIG. 1) runs to the substantia nigra when extended distally. Thus, the seating of the fiber optic in the SN may be safely accomplished by simply using the conventional procedure for STN-electrode placement and extending the path distally. In this embodiment, the fluence of the light may be such that the light a stimulating dose (e.g., between about 0.1 J/cm² and 10 J/cm²) to a portion of the substantia nigra contacting the fiber optic.

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Preferably, the fiber optic is placed so that it is in the middle third of the substantia nigra. Thus, in some embodiments wherein the substantia nigra is effectively irradiated, the distal end of the fiber optic is streotactically seated in the substantia nigra (SN) by passing through the STN.

In some embodiments wherein the substantia nigra is effectively irradiated, the distal end of the fiber optic is seated within the substantia nigra.

As shown in FIG. **12**, a horizontal section of the midbrain at the level of the mammillary bodies (MBs), the substantia nigra has a fairly central location in the midbrain. It runs substantially in the anterior-posterior direction, and its anterior tip lies adjacent to and slightly lateral to its corresponding MB. As shown in FIG. **12**, a perspective view of the substantia nigra, the substantia nigra lies between the mammillary bodies and the cerebral aqueduct. Its rostral portion is substantially at the level of the MBs, and it extends caudally from that level. The depth of the posterior aspect of the substantia nigra appears to be greater than its anterior aspect. As shown in FIG. **13**, a sagittal centerline section of the midbrain, the anterior portion of the substantia nigra (in ghost) lies lateral to the interpeduncular fossa. Moreover, it lies at a fairly significant depth (e.g., at least 1 cm) below the floor of the third ventricle.

In some embodiments, the distal end of the fiber optic is passed through the floor of the third ventricle, through the mammillary body (MB) and into the substantia nigra. As shown in FIG. **12**, the mammillary body appears to be adjacent the anterior portion of the substantia nigra. Therefore, the substantia nigra can be safely accessed by merely passing the fiber optic through the mammillary bodies (MBs) in an anterior to posterior direction.

A review of the anatomy in and around the mammillary bodies reveals that there appears to be a great deal of redundant circuitry related to the primary functions of mammillary bodies (MBs). Vann, *Nature Reviews: Neuroscience*, Volume 5 January 2004, 35-44 reports that MBs primarily receive projections from the hippocampus and primarily project to the thalamus. Thus, there is an indirect route from the hippocampus to the thalamus through the MBs. However, Vann, supra, also reports the presence of tracts that project directly from the hippocampus to the thalamus. Thus, there appear to be two routes from the hippocampus to the thalamus—one direct and one indirect through the MBs. Without wishing to be tied to a theory, it is believed that the brain will respond to damage to the MBs by using the direct route from the hippocampus to the thalamus. Thus, MBs appear to have a non-critical role in memory.

The non-critical nature of mammillary bodies towards memory appears to be supported by human studies. Duprez, *Am. J. Neuroradiology* 26:195-198, January 2005, reports that three epilepsy patients received electrodes in their mammillary bodies without having any memory deficit. Victor, *Int'l J. Neurol.*, 1987-8, 21-22, 51-7, concludes that mammillary bodies are irrelevant to amnesia.

Therefore, because MBs appear to have a non-critical role in memory, in some embodiments, bilateral fiber optics are passed through each of the mammillary bodies and into the adjacent substantia nigrae.

In some embodiments, the MB is accessed through an anterior approach in the horizontal plane. As shown in FIG. **11**, third ventricle space lies directly anterior to the mammillary bodies (as the 3rd ventricle floor ascends anteriorly to posteriorly in this area), while the substantia nigrae lie posterior and slightly lateral to their respective mammillary bodies.

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As it appears that the mammillary body lies in the same plane as its respective substantia nigra, once the fiber optic is passed through the mammillary body, it can continue to be advanced along the same line until it traverses essentially the entire substantia nigra structure. FIGS. 14a and 14b shows the midbrain with a distal end portion 505 of a fiber optic extending from the upper anterior portion of the substantia nigra to the upper posterior portion of the substantia nigra. In this embodiment, the fiber optic runs substantially along the top of the substantia nigra. Because the substantia nigra is substantially straight in the horizontal cross section, it is believed that the fiber optic can be inserted linearly through the substantia nigra and not intrude upon neighboring neural structures.

As the substantia nigra substantially descends posteriorly, the trajectory of the fiber optic passing through the mammillary body could likewise be a descending one in order to pass through as much of the substantia nigra as possible. In some embodiments, as in FIG. 15, the distal end 507 of the fiber optic is advanced through the mammillary body to contact the rostral tip of the substantia nigra adjacent the mammillary body, and is then advanced into the substantia nigra, and is advanced posteriorly to the opposite lower corner of the substantia nigra structure. In this manner, illumination of the distal end portion of the fiber optic will result in an illumination of the substantial breadth of the entire substantia nigra structure, from the upper anterior corner to the lower posterior corner.

It is noted that the fiber optic is relatively thin in relation to the substantia nigra structure. Because of this relatively thin dimension, it is believed that a thin fiber optic can suitably extend far into the substantia nigra without causing substantial damage to the overall nigral structure. For example, a typical substantia nigra has a 5 mm height, a 15 mm length and a 3 mm width, amounting to an overall volume of about 225 mm³. In contrast, a fiber optic having a diameter of about 0.1 mm that traverses the length of the substantia nigra has a volume of only about 1.5 mm³, or about 1% of the substantia nigra structure.

Despite the minimal invasion by the fiber optic, the fiber optic so situated is now located so as to beneficially irradiate at least half the entire substantia nigra structure with therapeutic red/NIR light. For example, if the fiber optic is emitting energy sufficient to provide 10 J/cm² of red/NIR light substantially adjacent the distal end of the fiber optic, then (assuming a penetration depth of about 2 mm) a cylinder having a radius of about 3 mm will be irradiated with between 0.1 J/cm² and 10 J/cm² of red/NIR light.

(Likewise, if the immediate vicinity is irradiated with 100 J/cm² (and so has less than optimal red/NIR light irradiation), then (assuming a penetration depth of about 2 mm) the sphere experiencing from 10-0.1 J/cm² increases to a radius of about 5 mm.) Since the typical substantia nigra has a 5 mm height, a 15 mm length and a 3 mm width, this irradiation should beneficially irradiate substantially all of the substantia nigra.

FIG. 15 shows the midbrain-fiber optic diagram of FIG. 15, along with the expected 5 mm radius (dotted line) zone of beneficial influence provided by red/NIR light.

Because the fiber optic will now be present in the substantia nigra, there will be essentially no dissipation of light between the fiber optic and the target structure. This will allow for the use of relatively low fluences at the tip of the fiber optic, thereby ameliorating heat and hyperirradiation concerns.

Now referring to FIG. 16a, in some embodiments associated with the traversal of the substantia nigra, the distal end portion of fiber optic has a straight distal portion and helical proximal portion. The distal end portion 509 is straight in order to minimize the invasion of the substantia nigra. The

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proximal portion 511 is helical in order to provide a sound anchor within the mammillary body. FIG. 16b shows a distally straight-proximally helical fiber optic embedded within the midbrain.

It is further noted that, anatomically, the lateral portion of the mammillary body does not hang down into the interpeduncular fossa, but rather appears to be fully attached to the floor of the third ventricle. Because of this fusion of tissues, it appears that a relatively large diameter fiber optic can be safely passed through this region of the mammillary bodies without fear of disrupting fossa vascularity. Now referring to FIGS. 17a and 17b, in some embodiments associated with the traversal of the substantia nigra, the distal end portion 513 of fiber optic is completely helical. The helical nature of the fiber optic will allow the surgeon to substantially traverse the width of the substantia nigra with the fiber optic, thereby providing a substantially uniform illumination of the tissue within the helix. Therefore, when the distal end portion is helical, the helix provides a) uniform illumination of the substantia nigra which it encloses, and b) a sound anchor within the mammillary body and midbrain. FIG. 18 shows a helical fiber optic 515 embedded within both the mammillary body and substantia nigra, and traversing the substantia nigra with a downwards descent.

Damier, *Brain* 1999, August 122(Pt. 8; 1437-48 (Damier) reports on the heterogeneous nature of the substantia nigra pars compacta, and in particular on the clustering of dopaminergic neurons in regions five distinct regions labeled nigrosomes N1-N5. These nigrosomes, which comprise about 40% of the dopaminergic SN cells, are located in the intermediate-caudal regions of the substantia nigra. See FIG. 19. Damier further reports that these nigrosomes in general (and the N1 nigrosome in particular) appear to lead the SN in dopaminergic cell loss, both temporally and quantitatively.

It is believed by the present inventors that these nigrosomes should be specifically targeted for red/NIR light therapy. Therefore, in some embodiments of the present invention, the distal end of the fiber optic therapeutically irradiates at least one nigrosome of the SN. Preferably, the distal end of the fiber optic therapeutically irradiates at least the N1 nigrosome of the SN. More preferably, the distal end of the fiber optic therapeutically irradiates at least the N1 nigrosome of the SN with between 1 J/cm² and 10 J/cm² of red/NIR light. In some embodiments of the present invention, the distal end of the fiber optic is seated in the STN and therapeutically irradiates at least one nigrosome of the SN. In some embodiments of the present invention, the distal end of the fiber optic is seated in the PPN and therapeutically irradiates at least one nigrosome of the SN. In some embodiments of the present invention, the distal end of the fiber optic is seated in the SN and therapeutically irradiates at least one nigrosome of the SN. In some embodiments of the present invention, the distal end of the fiber optic is seated in the N1 nigrosome and therapeutically irradiates the N1 nigrosome of the SN.

It is further noted that the axis of the substantia nigra (A-A' in FIG. 20) does not align with the axis of the 3rd ventricle (B-B' in FIG. 20), but rather runs substantially parallel to it. This "misalignment" of axes means that a straight fiber optic can not simply enter the mammillary body along the axis of the 3rd ventricle and continue on to traverse the substantial length of the substantia nigra. It is noted that a tube 519 in the form of one half period of a helix has the property of essentially laterally shifting the longitudinal axis of a fiber optic 521 running through it. See FIG. 21a. Therefore, in some embodiments, a hemi-helical anchor tube 523 is placed in the mammillary body in order to laterally shift the longitudinal axis of a fiber optic 525 running through it (see FIG. 21b). In

some embodiments, the hemi-helical anchor tube is placed in the mammillary body by threading it into place with the help of a helical stylet.

The use of a hemi-helical anchor tube of the present invention carries with it three advantages over a simple straight insertion of a straight fiber optic. First, as noted, laterally shift the longitudinal axis of a fiber optic running through it so that the fiber optic can traverse a greater portion of the substantia nigra. Second, it carries the fiber optic farther away from the interpeduncular fossa, thereby adding a measure of safety. Third, it provides a means of anchoring the fiber optic. The half-helical nature of the anchor tube provides a means of anchoring the tube in the mammillary body. See FIG. 22. The internal bore 527 of the hemi-helical anchor tube can be threaded to mate with a matching thread 529 upon the fiber optic. When the threaded portion of the fiber optic enters the tube, the fiber optic is rotated, thereby locking the fiber optic to the anchor tube.

It is further noted that if the exit of the half-helical anchor tube is slightly varied to be slightly greater or less than one-half a period, then the plane upon which the fiber optic exits the tube can differ from the plane upon which the fiber optic enters the tube. Making such a tube 531 would allow the fiber optic 533 to enter the mammillary body in the horizontal plane of the midbrain and exit the mammillary body in a descending manner. Such a descent could be desirable because the substantia nigra extends significantly downward from the mammillary body (as shown in FIG. 23).

The direction of the fiber optic exiting the helix can be adjusted to the surgical need. In one embodiment, the outer surface of the helical tube remains helical, but the distal end of the inner bore is modified to alter the angle of exit. This property is demonstrated in FIGS. 24a-24c. FIG. 24a is a conventional helical tube portion 535 having a helical bore 537. The direction of the fiber optic exiting the tube (shown by the arrow) is equal to the tangent at the distal end of the tube. FIG. 24b is similar to FIG. 24a, but differs in that the exit surface 539 of the tube is angled. Again, the direction of the fiber optic exiting the tube (shown by the arrow) is equal to the tangent at the distal end of the tube. The helix of FIG. 24c has an outer surface 541 that has a helical shape, but its bore is modified in the area of the tube exit 543 to produce a different exit direction. Thus, modifying the bore at the exit will allow the production of a predetermined exit direction.

In some embodiments, the hemi-helical anchor tube 545 is carried on the outer surface 547 of a cylindrical plug 549 (as shown in FIG. 25a). This embodiment simply requires the surgeon to linearly insert the plug into the mammillary body, taking care to orient the plug so that the entrance and exits of the tube are in their desired places.

In some embodiments, the hemi-helical anchor tube 551 is carried on the outer surface 553 of a cylindrical annulus 555 (as shown in FIG. 25b). The annulus embodiment has all the advantages of the plug design discussed directly above, but causes less damage to the mammillary body.

In some embodiments, the hemi-helical anchor tube 557 is carried on the outer surface 559 of a cylindrical mesh 561 (as shown in FIG. 25c). The mesh embodiment has all the advantages of the annular design discussed directly above, but allows for more repair of the mammillary body.

The anchor tube annulus combination of FIG. 25d is substantially similar to that of FIG. 25b, except that the anchor tube 563 runs for essentially one-half of a period. This device can be advantageously inserted into a mammillary body and thereby shift the axis of the fiber optic in a manner similar to that of FIG. 21b.

In some embodiments, the hemi-helical anchor tube is made of a shape memory metal that is inserted in a linear fashion and then bends into an angled shape upon heating.

Moreover, if the mammillary bodies are a redundant structure, then they can be over-irradiated without causing any overall harm.

If the therapeutic light treatment of the present invention can over-irradiate the mammillary bodies, then the surgeon is able to treat the mammillary body as an effective extension of the fiber optic. Thus, the treatment can irradiate the mammillary bodies so as cause the bodies to become an effective light source. This approach could decrease the distance of the "light source" to the substantia nigra from 1 cm (fiber optic-to-SN distance) to no more than about 0.5 cm (MB-to-SN distance), and even less in some areas wherein the mammillary body essentially abuts the substantia nigra. For example, this type of treatment may irradiate the mammillary bodies so that their posterior surfaces have a fluence of about 10 J/cm² of red/NIR light. Because there is nearly contact between the posterior portion of the MBs and the anterior tip of the substantia nigra (SN), the anterior tip of the SN will likely receive about 10 J/cm² of red/NIR light from the overirradiated MBs. Substantia nigral structure downstream of this tip will then receive the red/NIR light in a therapeutic dose of between 0.1 J/cm² and 10 J/cm². This could include an anterior span of the substantia nigra having a length of about 7 mm, or about half of the substantia nigra.

Likewise, if the center of the mammillary body is irradiated so that its posterior surface experiences a fluence of 100 J/cm², then (assuming a penetration depth of about 2 mm) the sphere of midbrain experiencing red/NIR light in the therapeutic range of about 20-0.01 J/cm² may have a radius of about 8 mm. Since the typical substantia nigra has a 5 mm height, a 15 mm length and a 3 mm width, this irradiation should beneficially irradiate substantially 2/3 of the substantia nigra. Moreover, if the red/NIR light is able to provide therapy at fluences as low as 0.001 J/cm² (as per Byrnes), then the radius of influence would be even larger.

Since the patient with Parkinson's Disease begins to display motor disabilities when about 80% of the dopaminergic substantia nigral neurons have died, it is believed that any treatment that therapeutically treats about 20% of the dopaminergic cells may have a significant impact. Therefore, a treatment involving overirradiation of the mammillary bodies that results in the ability to treat about half of the substantia nigra would appear to be worthwhile.

Therefore, the surgeon can place a fiber optic on the floor of the third ventricle (using ventriculostomy techniques) and irradiate just the mammillary bodies. This would effectively make the MBs a light bulb that shines therapeutic red/NIR light upon the substantia nigra.

In some of these embodiments involving overirradiation of the mammillary bodies, and now referring to FIG. 26, a distal end 565 of a fiber optic is implanted into the mammillary body, and light is flowed into the mammillary body such that its posterior surface has a light fluence of about 10-100 J/cm². In some of these embodiments, the distal end of the fiber optic preferably has a helical shape. The helix structure performs three important functions. First, it anchors the fiber optic in the region of interest. Second, it provides uniform light within the internal structure of the mammillary bodies. Lastly, it may be sized so that its disappearance from the 3rd ventricular floor signals the surgeon that the helix has entered the mammillary body to a sufficient depth, thereby helping avoid its entering the interpeduncular fossa.

In other embodiments, overirradiation of the mammillary bodies is accomplished without anchoring the fiber optic in

the mammillary body. In these embodiments, and now referring to FIG. 27 anchoring the fiber optic 567 involves fixing a proximal portion of a rigid fiber optic to either the dura or skull. Such proximal anchoring, which is commonly adopted in the anchoring of electrodes for deep brain stimulation, would automatically fix the distal end of a semi-rigid, appropriately-sized fiber optic to the mammillary body. The fiber optic travels through a lateral ventricle, through the foramen on Monro, and seats upon the mammillary body.

Therefore, in some embodiments, a distal end portion of the fiber optic is placed on the floor of the anterior third ventricle while its proximal end is fixed to the skull or dura. If the floor of the third ventricle is a somewhat flexible structure so that it has an elastic response to pressure, then the length of the fiber optic could be set so that the distal end of the fiber optic is snugly fit with the mammillary body. In this condition, slight distal movement of the fiber optic would provide a slightly more snug fit and slight proximal movement of the fiber optic would provide a slightly less but still snug fit. Throughout the range of movement, the distal end of the fiber optic could be in contact with the floor of the third ventricle next to the mammillary body.

This method of fixing a proximal portion of a rigid fiber optic to either the dura or skull has the advantage of avoiding any mechanical invasion of the mammillary body.

Therefore, in accordance with the present invention, there is provided a method of treating a patient having Parkinson's Disease, comprising the steps of:

- a) providing an optical wave guide having a proximal end portion and a distal end portion;
- b) endoscopically implanting the distal end portion of the optical wave guide onto a floor of the patient's third ventricle, and
- c) delivering light through the optical wave guide to irradiate at least a portion of a substantia nigra with an effective amount of light.

Because the delivery and placement of the fiber optic takes places substantially entirely within the ventricular system of the brain, such delivery and placement may be performed endoscopically. The endoscopic delivery and placement of this system represents a significant advantage over the conventional stereotactically-guided placement of medical devices in the brain. First, whereas stereotactically guided systems require the use of expensive and complicated hardware, endoscopic placement of a tube within the cerebral aqueduct is relatively straightforward and can be performed without expensive and time-consuming support equipment. Second, stereotactically guided systems typically require blunt invasion of the brain parenchyma and its related vasculature, and so generate a risk of producing neural deficits and hemorrhage. For example, Kleiner-Fisman, *Mov. Disord.*, 2006, Jun. 21, Suppl. 14 S290-304 reports a 3.9% hemorrhage rate for Parkinson's patients receiving deep brain stimulation implants. In contrast, endoscopic placement of a fiber optic in the 3rd ventricle does not produce any injury to the brain tissue or its related vasculature whatsoever, and so therefore should eliminate the risk of hemorrhage.

In sum, endoscopically accessing the ventricular system is much less complicated than placing a catheter directly into the brain parenchyma. Endoscopic access could be performed by most neurosurgeons and so there would be no need to require stereotactic-trained surgeons or stereotactic/navigation equipment. Most neurosurgeons are capable of and would be comfortable placing a tube into the lateral ventricle and driving that catheter into the floor of the third ventricle endoscopically and then into the mammillary body. Anatomic landmarks would facilitate its placement and this would obvi-

ate the need for complex stereotactic localizing techniques. It would a simpler procedure for patients and could be performed by most neurosurgeons.

Therefore, in accordance with the present invention, there is provided a method of treating a patient having Parkinson's Disease, comprising the steps of:

- a) providing an optical wave guide having a proximal end portion and a distal end portion;
- b) endoscopically implanting the distal end portion of the optical wave guide into the patient's mammillary body, and
- c) delivering light through the optical wave guide to irradiate at least a portion of a substantia nigra with an effective amount of light.

In some embodiments using endoscopic placement, a modified procedure of Farin, "Endoscopic Third Ventriculotomy" *J. Clin. Neurosci.* August; 13(7):2006, 763-70 is used. In particular, a burr hole is made through the skull at the intersection of the coronal suture and the midpupillary line, approximately 2-3 cm lateral to the midline. The endoscope trajectory is aimed medially toward the medial canthus of the ipsilateral eye and toward the contralateral external auditory meatus in the anterior/posterior plane. This approach leads to the foramen of Monro and floor of the third ventricle. The lateral aspect of the anterior (adult) fontanelle is targeted. The dura is opened. The lateral ventricle is tapped using a peel-away sheath with ventricular introducer. The sheath is secured in place to the scalp. A rigid neuroendoscope is then inserted into the lateral ventricle, and the choroid plexus and septal and thalamostriate veins are identified in order to locate the foramen of Monro. The endoscope is advanced into the third ventricle. The mammillary bodies are some of the more posterior landmarks of the third ventricle; moving anteriorly, the basilar artery, dorsum sellae and infundibular recess may be obvious based on the degree of attenuation of the ventricular floor. The endoscope is then moved farther posteriorly to the mammillary bodies. The endoscope then deposits the distal end of the fiber optic in the mammillary body.

This endoscopic approach provides both a safety, time and efficacy advantage over stereotactic placement of fiber optics in various midbrain structures.

First, since there is about a 4% risk of hemorrhage associated with STN deep brain stimulation, it is reasonable to expect that stereotactic placement of the fiber optic near the substantia nigra will have a similar risk (or twice that 4% risk for bilateral fiber optic placement). In contrast, the endoscopic placement of fiber optics through the third ventricle will likely eliminate that risk.

Second, stereotactic placement of bilateral fiber optics near the substantia nigra requires bilateral access and so requires making two burr holes in the cranium. In contrast, endoscopic placement of fiber optics through the third ventricle requires only a single access hole in the cranium. In some embodiments, bilateral placement of fiber optics in the mammillary bodies is accomplished endoscopically through the same opening in the cranium. Because the mammillary bodies are adjacent to each other on the floor of the third ventricle, only a single approach need be made. In preferred embodiments, a single opening in the skull is made and a path is bored through the brain to the anterior portion of the lateral ventricle. Each of the optical fibers is then fed down this path and enters the same lateral ventricle from the cranium. Next, the fibers are guided through the pertinent foramen of Monro, pass downward through the third ventricle to its floor, and are placed into or on one of the adjacent mammillary bodies.

Third, whereas anchorage of the stereotactically placed fiber optics will likely adopt the DBS method of anchoring a

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proximal portion of the fiber optic to the skull or dura, many of the embodiments disclosed above use anchorage of helices in the mammillary bodies and so is a much simpler anchorage procedure.

Fourth, stereotactic placement of bilateral fiber optics near the substantia nigra uses an approach that is essentially transverse to the length of the substantia nigra, and so irradiates only a small portion of the substantia nigra. In contrast, endoscopic placement of fiber optics through the third ventricle and mammillary bodies uses an approach that is well suited to allowing the surgeon to traverse the entire length of the substantia nigra with the fiber optics.

In other endoscopic embodiments, the optical wave guide and/or light source is placed in the anterior horn of the lateral ventricle, and light emanating therefrom therapeutically irradiates the caudate nucleus.

Therefore, in accordance with the present invention, there is provided a method of treating a patient having Parkinson's Disease, comprising the steps of:

- a) providing an optical wave guide having a proximal end portion and a distal end portion;
- b) endoscopically implanting the distal end portion of the optical wave guide into an anterior horn of the patient's lateral ventricle, and
- c) delivering light through the optical wave guide to irradiate at least a portion of a caudate nucleus with an effective amount of light.

Therefore, in accordance with the present invention, there is provided a method of treating a patient having Parkinson's Disease, comprising the steps of:

- a) providing an red/NIR LED,
- b) endoscopically implanting the LED into an anterior horn of the patient's lateral ventricle, and
- c) delivering light from the LED to irradiate at least a portion of a caudate nucleus with an effective amount of light.

In some embodiments, a unilateral fiber optic is passed through a lateral aspect of a single mammillary body. Blair, *J. Neuroscience*, Aug. 1, 1999, 19(15) 6673-83 examined the effect of lesioning one and both of the mammillary bodies in rats, and reports that anterior thalamic head-direction signal is abolished by bilateral but not unilateral lesions of the lateral mammillary nucleus. Blair concludes that the lack of damage in the unilateral model is due to the fact that a single lateral mammillary nucleus projects bilaterally to each anterodorsal thalamus. Therefore, it appears that there is substantial redundancy in the circuitry of a pair of lateral mammillary nuclei.

In embodiments in which the fiber optics pierce the mammillary bodies, it is important to attain the proper angle of entry. This angle should be sufficiently wide in the horizontal plane in order to avoid entering the interpeduncular fossa. This angle should also be sufficiently axial in the sagittal plane in order to angle downward into the middle of the substantia nigra. These angles can be determined from pre-operative MRIs. Now referring to FIG. 28, once the appropriate angle has been established, the distal end of the endoscope can be made into a tripod 571 that mimics the appropriate angle of entry when placed in the middle of the mammillary bodies.

In some embodiments, the fiber optic is run through the temporal horn of the lateral ventricle, exiting the lateral ventricle at the choroidal fissure. The choroidal fissure is a gap located on the medial wall of the anterior end of the temporal horn of the lateral ventricle. The choroidal fissure essentially opens onto a posterior portion of the substantia nigra (located next to the medial geniculate nucleus).

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Thus, in these embodiments using the choroidal fissure as a pathway, and now referring to FIG. 29, the distal end 573 of the fiber optic may be advantageously placed on the outer surface of the midbrain adjacent to the posterior portion of the substantia nigra. From this position, the fiber optic may non-invasively illuminate the posterior portion of the substantia nigra.

It is believed that illuminating the posterior portion of the substantia nigra will produce a therapeutic benefit. It is believed that patients with Parkinson's Disease begin to experience motor symptoms when less than about 20% of their substantia nigra cells survive. It is further believed that illuminating the outer surface of the midbrain from a location next to the medial geniculate nucleus will beneficially irradiate at least about 25% of the substantia nigra. Accordingly, this therapy should serve to save and/or regrow enough of the substantia nigra to reduce and/or eliminate PD disabilities.

In some embodiments, the distal end portion of the fiber optic comprises a tubular shape that is anchored within the choroidal fissure. If required, the choroidal fissure may be fenestrated or opened in order to accommodate the distal end portion of the fiber optic.

In some embodiments involving access to the substantia nigra through the choroidal fissure, bilateral placement of fiber optics in the lateral ventricles is accomplished through the same opening in the cranium. Whereas the first fiber optic remains in the lateral ventricle that it initially enters, the second fiber optic is guided through the first foramen of Monro, through the third ventricle, through the second foramen of Monro and into the second lateral ventricle. In this way, only a single opening in the skull need be made in order to have bilateral treatment of the substantia nigra structures.

Some embodiments of the present invention involve access to the substantia nigra through the ambient cistern. For example, these approach could include an approach through the choroidal fissure, or through a supracerebellar or subtemporal approach. In these embodiments, the distal end of the fiber optic is advanced through the ambient cistern to the tip of the substantia nigra adjacent the medial geniculate nucleus, and is then inserted into the substantia nigra, and is advanced to the opposite corner of the substantia nigra structure. In this manner, illumination of the distal end portion of the fiber optic will result in an illumination of the substantial breadth of the entire substantia nigral structure, from the lower posterior corner to the upper anterior corner.

Therefore, in accordance with the present invention, there is provided an implant for treating Parkinson's disease comprising:

- a) an implantable energy storage device (such as a battery),
- b) a Red/NIR light emitting diode (LED) in electrical connection with the implantable energy storage device, and
- c) an optical wave guide having a helical portion.

Therefore, in accordance with the present invention, there is provided a method of treating a patient having a neurodegenerative disease (such as Parkinson's disease), comprising the steps of:

- a) providing an implant comprising:
 - i) an implantable electrical power source (such as a battery),
 - ii) a Red/NIR light emitting diode (LED) in electrical connection with the implantable energy storage device, and
 - iii) an optical wave guide having a helical portion, the guide extending from the LED,
- b) extracranially implanting the power source in the patient (preferably, in the chest of the patient),
- c) implanting the LED within the skull of the patient (preferably within a ventricle), and

- d) implanting the optical wave guide within the brain of the patient (preferably, near the substantia nigra), and
- e) activating the power source to cause red/NIR light irradiation of the brain of the patient.

We claim:

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1. A method of treating a patient having a neurodegenerative disease, comprising the steps of:

- a) selecting an optical wave guide having a proximal end portion and a distal end portion;
- b) endoscopically implanting the distal end portion of the optical wave guide into a lateral ventricle of the patient, and
- c) delivering light through the optical wave guide to irradiate at least a portion of a subventricular zone with an effective amount of light.

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2. A method of treating stroke, comprising the steps of:

- a) selecting a stroke patient, and
- b) delivering a distal end portion of an optical wave guide into a lateral ventricle of the patient, and
- c) irradiating through the optical wave guide at least a portion of a subventricular zone of the patient with an effective amount of red/NIR light.

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